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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14043

CERTIFICATE OF DEATH

14011

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): S. Arlington 83X-3
d. STREET ADDRESS: 4614 6th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edith — Middle: M — Last: Ailes
4. DATE OF DEATH: Month: December — Day: 6, — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 27, 1907
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Alfred H. McIantire
14. MOTHER'S MAIDEN NAME: Clara Hudson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma of lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
162.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ~~(I)~~ XX (this hospital) attended the deceased from Nov. 27, 19 61 to Dec. 6, 19 61 that ~~(I)~~ X (we) last saw the deceased alive on Dec. 6, 19 61, and that death occured at 7:58 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert E. DeForest M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 6, 1961
22c. PHYSICIAN'S NAME (Type): ROBERT E. DE FOREST LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-11-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington N tional
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: Arlington Funeral Home, Arlington, Va.
25a. REC'D BY REGISTRAR — DATE: DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14044 14012

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Monty Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenwood 13X2
d. STREET ADDRESS: Dorsey Mill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Charles Edward Anderson

4. DATE OF DEATH: Month: Dec; Day: 22; Year: 1961

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 10-6-61
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months: 2; Days: 16 IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Vernon Anderson
14. MOTHER'S MAIDEN NAME: Rosalie Bell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Rosalie Anderson (Mother) Address: Star 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Upper Respiratory Infection
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-61
22c. NAME OF CEMETERY OR CREMATORY: St. Louis
22d. LOCATION (City, town, or country) (State): Clarksville, Md

23. FUNERAL DIRECTOR: F.C.Higinbothom, Ellicott City, Md — ADDRESS
24a. REC'D BY REGISTRAR DATE: DEC 26 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14045 **CERTIFICATE OF DEATH** 14013

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 28
d. STREET ADDRESS: 2001 Hanover St S.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter; Middle: Andrew; Last: Anderson

4. DATE OF DEATH: Month: Dec.; Day: 4; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 17-1889

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months: ; Days:

IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - office Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Brooklyn New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew Anderson

14. MOTHER'S MAIDEN NAME: Hanna Borgenson.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 577-10-3205

17. INFORMANT: Mr. Robert A. Anderson
Son. 12,600 Barbara Road, Silver Spring, Md.
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
443X
DUE TO (b): Hypertension - Arteriosclerosis — —
DUE TO (c): Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1955 to Dec 4, 1961, that (I) (we) last saw the deceased alive on Dec 4 1961, and that death occured at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J. Marion Bankhead M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): J. Marion Bankhead

22d. ADDRESS: 9241 Col. Blvd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12/7/61

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

23d. LOCATION (City, town or county) (State): PRINCE GEORGE'S, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Liska
HARVEY E. PUMPHREY, INC.

ADDRESS: 8434 GEORGIA AVENUE SILVER SPRING, MARYLAND

25a. REC'D BY REGISTRAR DATE: DEC 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14046 14014

1. PLACE OF DEATH
a. COUNTY: Montg. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 2Yr 8Mo
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Asbury Methodist Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

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3. NAME OF DECEASED (Type or print): First: John Middle: Wilbur Last: Arnold

4. DATE OF DEATH: Month: Dec. Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 16-1880

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months: 10 Days: 5 IF UNDER 24 HRS.: Hours: Min.:

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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Baltimore. Md.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: George Washington Arnold

14. MOTHER'S MAIDEN NAME: Laura Virginia Martzell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Records. Asbury Methodist Home Address: Gaithersburg

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis, Generalized — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO (b) Carcinoma of Prostate — 13 mos.
DUE TO (c)

177X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 1960, to Dec. 19 1961, that (I) (we) last saw the deceased alive on Dec 14 1961, and that death occurred at 11 23 4 M, from the causes and on the date stated above.

22a. SIGNATURE: James W Egan M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-19-61

22c. PHYSICIAN'S NAME (Type): James W. Egan

22d. ADDRESS: 7720 Wisconsin Ave. - Bethesda, Md

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23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-22-61

23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove

23d. LOCATION (City, town, or county) (State): Sandy Mount. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. ADDRESS: Gaithersburg. Md.

25a. REC'D BY REGISTRAR DATE: DEC 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14047 14015

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8000 PINEY BRANCH ROAD

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 TAKOMA PARK
d. STREET ADDRESS: 8000 PINEY BRANCH ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First DAISY Middle E. Last BARNHART
4. DATE OF DEATH: Month DEC. Day 25, Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 13, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: DAVID FRYE.
14. MOTHER'S MAIDEN NAME: IDA NICHOLSON.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: STANLEY R. BARNHART Address: 8000 PINEY BRANCH Rd. TAKOMA PARK, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia, Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
592 X
DUE TO (b) Chronic Glomerulo nephritis — 10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic Heart Disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from June, 1961, to 25 Dec, 1961, that (I) (~~we~~) last saw the deceased alive on 24 Dec 1961, and that death occured at 4.7 P.M, from the causes and on the date stated above.

22a. SIGNATURE: H. B. Queen M.D. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 25 Dec 1961
22c. PHYSICIAN'S NAME (Type): H. B. QUEEN
22d. ADDRESS: 7112 Willow Ave. TAKOMA PARK, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: DEC. 1961
23c. NAME OF CEMETERY OR CREMATORY: LEGONIER VALLEY CEM.
23d. LOCATION (City, town or county): LEGONIER (State) PENNA.
24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: 254 CARROLL ST. N.W. D.C.
25a. REC'D BY REGISTRAR DATE DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14048 **CERTIFICATE OF DEATH** 14016

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: Mercer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princeton
d. STREET ADDRESS: 46 Chestnut Street
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA Middle: L. Last: BARRON

4. DATE OF DEATH Month: Dec. Day: 10 Year: 1961

5. SEX: Female **6. COLOR OR RACE:** White **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/9/82

9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Librarian (ret.) **10b. KIND OF BUSINESS OR INDUSTRY:** Princeton U. **11. BIRTHPLACE** (County & State, or foreign country): Nova Scotia **12. CITIZEN OF WHAT COUNTRY?** Canadian

13. FATHER'S NAME: Andrew Barron **14. MOTHER'S MAIDEN NAME:** Mary?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no. **16. SOCIAL SECURITY NO.** **17. INFORMANT:** Edw. F. Carr Address: 7300 Wisconsin Ave Bethesda, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Infarction of Myocardium
DUE TO (b): Coronary atherosclerosis
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER) **20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f.** (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Spring, 1960 to Dec 10, 1961, that (I) saw the deceased alive on Dec. 10 1961, and that death occured at 1:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James W. Egan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ **22b. DATE SIGNED:** 12-10-61

22c. PHYSICIAN'S NAME (Type): James W. Egan **22d. ADDRESS:** 7720 Wisconsin Avenue, Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 12/11/61 **23b. DATE THEREOF** **23c. NAME OF CEMETERY OR CREMATORY:** St. Paul Cemetery **23d. LOCATION** (City, town or county) (State): Princeton, New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland **25a. REC'D BY REGISTRAR** DATE DEC 13 '61 **25b. REGISTRAR'S SIGNATURE** Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14049 **CERTIFICATE OF DEATH** 14017

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Resmore Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural Scotland
d. STREET ADDRESS: 187-
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Harry Middle: Alexander Last: Beal
4. DATE OF DEATH: Month: December Day: 10, Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Feb. 1872
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: ? ?
14. MOTHER'S MAIDEN NAME: ? ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records Address: Same as # 2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

420.1

DUE TO (b) CORONARY ARTERY DISEASE — 5 YEARS

DUE TO (c) ARTERIOSCLEROSIS, GEN'L — 10 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): URINARY TRACT INFECTION WITH UREMIA

19. WAS AUTOPSY PERFORMED? YES [ ] NO [✓]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 17, 1961, to 12/10, 1961, that (I) (we) last saw the deceased alive on 12/9 1961, and that death occured at 5:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Charles J. Savarese Jr. M.D. — ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/11/61
22c. PHYSICIAN'S NAME (Type): CHARLES J. SAVARESE JR
22d. ADDRESS: 4896 BATTERY LANE BETHESDA, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: St. Michaels
23d. LOCATION (City, town or county) (State): Ridge, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: W.Clarke Mattingley ADDRESS: Leonardtown, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Charles L. Fenwick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(47)

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14050 14013

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): X Rural- Lewisdale
d. STREET ADDRESS: RFD Clarksburg
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Bessie Middle: Lewis Last: Beall
4. DATE OF DEATH: Month: December Day: 30 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: July 21, 1893
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (County & State, or foreign country): Lewisdale, Md.
12. CITIZEN OF WHAT COUNTRY?: USA
13. FATHER'S NAME: Filmore Lewis
14. MOTHER'S MAIDEN NAME: Olive M. Watkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr. Leslie G. Beall, Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Generalized Arteriosclerosis with Coronary Sclerosis — 8 years ?
DUE TO (c) Hypertensive Arteriosclerotic Cardio-vascular Disease with Congestive Heart Failure. — 5 years?

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus - Severe. Congestive Heart Failure Hypertensive Arteriosclerotic Cardio-Vascular Disease

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Relate cause of injury to death in 18 above)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1935, 19..., to December 30, 1961, that (I) (this) last saw the deceased alive on Dec. 30, 1961, and that death occured at 12:00 M, from the causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer, M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12/31/61
22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.
22d. ADDRESS: 9830 Main Street, Damascus, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2, 1962
23c. NAME OF CEMETERY OR CREMATORY: Bethesda Methodist
23d. LOCATION (City, town or county) (State): Browningsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth
ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR DATE: JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14051 14019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible]ely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon [illegible]pers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 BETHESDA
d. STREET ADDRESS: 4605 West Va. Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle M Last BECK

4. DATE OF DEATH: Month DEC. Day 31 Year 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/12/1901
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painting
10b. KIND OF BUSINESS OR INDUSTRY: Contractor
11. BIRTHPLACE (County & State, or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George W. Beck
14. MOTHER'S MAIDEN NAME: Icey Lindsay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 325-14-2167
17. INFORMANT: Lillian S. Beck — Address: Wife Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 11 days
DUE TO (b) Thrombosis, Left anterior descending coronary artery
DUE TO (c) Arteriosclerosis
420
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from JUNE 22, 1961, to DEC. 31, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 30, 1961, and that death occured at 9:35 A.M., from the causes and on the date stated above.

22e. SIGNATURE: Robert G. Angle M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/31/61
22c. PHYSICIAN'S NAME (Type): Robert Angle
22d. ADDRESS: 5009 DelRay Avenue, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/3/62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ~~Fun~~ ADDRESS: Bethesda, Md.
25e. REC'D BY REGISTRAR DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

VR A15 (4)
15M 9/60

Myocardial infarct
Thromboembolic infarction
Pulmonary artery

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14052 14020

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural- Clarksburg
c. LENGTH OF STAY IN 1b: years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD # 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Clarksburg
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Della — Middle: F. — Last: Bennett

4. DATE OF DEATH: Month: Dec. — Day: 12 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: Aug. 15, 1882

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (County & State, or foreign country): Montgomery Co., Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W.F.L. Clagett

14. MOTHER'S MAIDEN NAME: Henerietter Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Dosey L. Bennett, — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertensive Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.
443X
DUE TO (b) Auricullar Fibrillation — 14 yrs.
DUE TO (c) Generalized Arteriosclerosis — 15 yrs. ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute Gastro-enteritis (Viral?)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Not an accident

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 1941 to December 12, 1961, that I (we) last saw the deceased alive on December 12, 1961 and that death occured at 2P M, from the causes and on the date stated above.

22a. SIGNATURE: M. McKendree Boyer M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: Dec. 13, 1961

22c. PHYSICIAN'S NAME (Type): M. McKendree Boyer, M. D.

22d. ADDRESS: 9830 Main Street, Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec.15,1961

23c. NAME OF CEMETERY OR CREMATORY: Clarksburg Meth.

23d. LOCATION (City, town or county) (State): Clarksburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Olin L. Mohsmith — ADDRESS: Damascus, Md.

25a. REC'D BY REGISTRAR DATE DEC 18 '61

25b. REGISTRAR'S SIGNATURE: Anthony L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14053 14021

1. PLACE OF DEATH - a. COUNTY: Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md.

c. LENGTH OF STAY IN 1b: 4mo.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Althea Woodland , 1000 Daleview Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: ~~Maryland~~ Washington D.C.

b. COUNTY: ✓

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C.

d. STREET ADDRESS: 4607 Conn. Ave. N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elsie Middle: Havener Last: Bennett

4. DATE OF DEATH: Month: December Day: 17, Year: 1961

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11,1878

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk General Acconting

10b. KIND OF BUSINESS OR INDUSTRY: office

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wesley Francis Havener

14. MOTHER'S MAIDEN NAME: Martha Ann Cleary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Elsie H. Bennett, Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days

DUE TO (b): Hypertension — 3 yrs

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Psychotic state

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/1/59 to 12/17/61 that (I) (we) last saw the deceased alive on 12/12/61, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: C H Wolohon M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): C. H. Wolohon

22d. ADDRESS: 800 Pershing Dr. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/19/61

23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

23d. LOCATION (City, town or county) (State): Rock Creek Church Rd. Wash.DC

24 FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, Inc.

ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE DEC 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14054 **CERTIFICATE OF DEATH** 14022

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 41 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Silver Spring
d. STREET ADDRESS: 2412 Dennis Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Oliver — Last: Berger
4. DATE OF DEATH: Month: December — Day: 18, — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2 February 1880
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~XXXXXXX~~ Insp. Mechanic of Ordnance
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy Dept.
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elias Berger
14. MOTHER'S MAIDEN NAME: Emma Hunsicker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
154X
DUE TO (b) Lymphoma
DUE TO (c) Post-op Carcinoma of rectum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from November 7, 1961 to December 18 1961, that (I) (we) last saw the deceased alive on December 18 1961, and that death occured at 2:10 PM from the causes and on the date stated above.

22a. SIGNATURE: Marvin Pomerantz M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-18-61
22c. PHYSICIAN'S NAME (Type): Marvin Pomerantz M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/21/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Liska — ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
Warner E. Pumphrey, Inc.
25e. REC'D BY REGISTRAR: DEC 22 '61
25b. REGISTRAR'S SIGNATURE: Conway S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14055 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14023

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Garrett Park
d. STREET ADDRESS: Waverly st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Henry — Last: Bettis

4. DATE OF DEATH: Month: Dec — Day: 29 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ?

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): labor

10b. KIND OF BUSINESS OR INDUSTRY: retired

11. BIRTHPLACE (State or foreign country): Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Bettis

14. MOTHER'S MAIDEN NAME: Susan Groves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wars or dates of service)

16. SOCIAL SECURITY NO.: 213-14-2239

17. INFORMANT: Robert J. Bettis — Address: 6505-2nd Ave Takoma Park Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county)

DATE SIGNED: 12-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 1/4/62

22c. NAME OF CEMETERY OR CREMATORY: Parklawn

22d. LOCATION (City, town, or country) (State): Rockville, Md.

23. FUNERAL DIRECTOR: Tyson Wheeler — ADDRESS: 1331 E. Jefferson Ave Rockville, Md.

24a. REC'D BY REGISTRAR: DATE JAN 5 '62

24b. REGISTRAR'S SIGNATURE: Arthur E. Hess

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14056 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14024

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Monty Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 15. Silver Spring
d. STREET ADDRESS: Colesville-Beltsville Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Bixiones Last
4. DATE OF DEATH: Month 12 Day 18 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-19-24
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dep Sheriff
10b. KIND OF BUSINESS OR INDUSTRY: Montgomery Co.
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Peter Bixiones
14. MOTHER'S MAIDEN NAME: Alice Christos
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW2
16. SOCIAL SECURITY NO.: 149-12-5240
17. INFORMANT: Joe P. Bixiones — Address: 13201 Kara Lane Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
929.8
DUE TO (b) drowning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Drowned while retrieving a duck which he shot
20c. TIME OF INJURY: Hour ? a.m. p.m. Month, Day, Year 12-18 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Pond
20f. (City or town) Silver Spring (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/21/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or country) Arlington (State) Virginia

23. FUNERAL DIRECTOR: Raymond A. Ziska — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 22 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Hines

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death; any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14057 **CERTIFICATE OF DEATH** 14025

Item 23b, Film G303 12/19/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Louisiana
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bossier City
d. STREET ADDRESS: 2273-A N. Plantation Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

56X-3

3. NAME OF DECEASED (Type or print): First: David; Middle: Leslie; Last: Blackwell

4. DATE OF DEATH: Month: December; Day: 12; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: November 11, 1961

9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months: 1; Days: 5; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (County & State, or foreign country): Louisiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jerry D. Blackwell

14. MOTHER'S MAIDEN NAME: Sybill Bizzell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service): - - - -

16. SOCIAL SECURITY NO.: - - - -

17. INFORMANT Address: FATHER: Jerry D. Blackwell, sam as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congenital Heart Disease (Transposition c A.S.D. & V.S.D.)
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

754.5

INTERVAL BETWEEN ONSET AND DEATH: 31 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 26, 1961, to Dec. 12, 1961, that (I) (we) last saw the deceased alive on Dec. 12, 1961, and that death occured at 2:00PM, from the causes and on the date stated above.

22a. SIGNATURE: M.C. O'Bannon M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: December 12, 1961

22c. PHYSICIAN'S NAME (Type): M. C. O'BANNON LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/16/61

23c. NAME OF CEMETERY OR CREMATORY: New Smyrna Cemetery

23d. LOCATION (City, town or county) (State): Smyrna, Ga.

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler
Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montgomery Ave Rockville, Md

25a. REC'D BY REGISTRAR DATE DEC 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14058 Items 4,18 & 22 Film G302 12/8/61 iwk 14026

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Loudoun
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Leesburg 83X·3
d. STREET ADDRESS: P.O.Box 628
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby; Middle: Lee; Last: Bodmer
4. DATE OF DEATH: Month: December; Day: 5; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: September 24, 1912
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Company
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert G. Cooper
14. MOTHER'S MAIDEN NAME: Ollie Atwell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 223-09-1520
17. INFORMANT: The Medical Record, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure, probably due to acute tubular necrosis — 8 days
DUE TO (b) Massive hemorrhage gastrointestinal, intra-pulmonary, retroperitoneal, peritoneal, peri-renal. — 9 days
DUE TO (c) Abcess, right femoral triangle, thrombosis R. iliac vein — 14 days

672.4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from Nov. 8, 1961 to Dec. 5, 1961 that (X) (we) last saw the deceased alive on Dec. 5, 1961, and that death occured at 4:30PM from the causes and on the date stated above.

22a. SIGNATURE: Yosef H. Pilch M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/5/61
22c. PHYSICIAN'S NAME (Type): Yosef H. Pilch, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 8, 1961
23c. NAME OF CEMETERY OR CREMATORY: Union
23d. LOCATION (City, town or county) (State): Leesburg VA

24. FUNERAL DIRECTOR'S SIGNATURE: J. L. Muse
ADDRESS: Leesburg, VA
25a. REC'D BY REGISTRAR DATE DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Clarence S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14059 **CERTIFICATE OF DEATH** 14027

1. PLACE OF DEATH
e. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 09
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Md. b. COUNTY: Mont. Co.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 519 Crabb Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mark Middle: Preston Last: Bonner.

4. DATE OF DEATH Month: Dec. Day: 23 Year: 1961

5. SEX: Male **6. COLOR OR RACE**: White **7. MARRIED** ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 12/24/61

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months: Days: 2 IF UNDER 24 HRS.: Hours: 7 Min.: 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Howard Bonner
14. MOTHER'S MAIDEN NAME: Joyce M. McKinney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mother's Chart. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
762.5
DUE TO (b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-21, 1961, to 12-23, 1961, that (I) (we) last saw the deceased alive on 12-23 1961, and that death occured at 20 M, from the causes and on the date stated above.

22a. SIGNATURE: Francis J. Troendle M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Francis J. Troendle
22d. ADDRESS: 809 Viers Mill Rd., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/61
23c. NAME OF CEMETERY OR CREMATORY: Forest Oak
23d. LOCATION (City, town or county) (State): Gaithersburg, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montgomery Ave. Rockville, Maryland
25a. REC'D BY REGISTRAR DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Esther L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14060 14028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8403 Old Georgetown Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 46 Bethesda
d. STREET ADDRESS: 8403 Old Georgetown Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward Middle: Last: Bowling
4. DATE OF DEATH: Month December Day 12 Year 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/20/78
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Capitol Transit Co.
11. BIRTHPLACE (County & State, or foreign country): Fredericksburg, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Florence Bowling Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis	Immediate
DUE TO (b)	Coronary atherosclerosis	5 years
DUE TO (c)	Generalized atherosclerosis	10 years

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Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Emphysema

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) ~~(this hospital)~~ attended the deceased from Jan 1, 1940 to Dec 12, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec 10 1964 and that death occured at 4:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Robert E. Maher M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Robert E. Maher M.D.
22d. ADDRESS: 1835 Eye St. N.W. Wash 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 12/15/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Clifton E. Hines

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14061 **CERTIFICATE OF DEATH** 14029

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 Month
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 29 Silver Spring
d. STREET ADDRESS: 8611 Mayfair Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Anita — Middle: Sawtelle — Last: Bracy

4. DATE OF DEATH: Month: Dec — Day: 5 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: March 28 1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hotel Owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Marcus Pliny Sawtelle

14. MOTHER'S MAIDEN NAME: Caesaria Arrigo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 571-38-7152A

17. INFORMANT (Address): Mrs. Emma Watterson (daughter)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO (b) Arteriosclerotic Cardiovascular Disease — 15 yrs.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from April 1, 1961 to Dec 5, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec 5 1961, and that death occured at 3:50 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George B Patrick Jr M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-5-61
22c. PHYSICIAN'S NAME (Type): George B. Patrick, Jr M.D.
22d. ADDRESS: 9221 Colesville Rd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/8/61
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN MAUSOLEIM
23d. LOCATION (City, town or county) (State): PRINCE GEORGE'S MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Zisk — **ADDRESS**: 8434 GEORGIA AVENUE
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND

25a. REC'D BY REGISTRAR DATE: DEC 7 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14063 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14030

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1½ hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rocky River 72-X-3
d. STREET ADDRESS: 21641 Lake Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Wirsing; Last: Bradshaw

4. DATE OF DEATH: Month: December; Day: 7; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 4, 1886

9. AGE (In years last birthday): 75 ~~80~~ yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Christian Tullner

14. MOTHER'S MAIDEN NAME: Rosa Engel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Address: Wm. W. Tullner, 5909 Greenlawn Dr., Beth., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1½ hrs.
DUE TO (b): Rupture of abdominal aneurysm
DUE TO (c):

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of aneurysm the past 5 years.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-7-61

EXAMINER'S NAME (Type): Frank J. Brochart
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 12-10-61

22b. DATE THEREOF:

22c. NAME OF CEMETERY OR CREMATORY: Lakewood Park Cem.

22d. LOCATION (City, town, or country) (State): Cuyahoga County, Ohio

23. FUNERAL DIRECTOR: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: DEC 13 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G305 1/8/62 mh

14062

CERTIFICATE OF DEATH

Reg.-Dist. No. 14031

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CARROLL HALL NURSING HOME.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND. — D. C.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON. MD Washington
d. STREET ADDRESS: 10231 Carroll Place 100 Kennedy St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

47X·3

3. NAME OF DECEASED (Type or print): First GILBERT Middle B Last BRADY.
4. DATE OF DEATH: Month 12/24/61 Day Year 19
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 29 1879 June 29, 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED.
10b. KIND OF BUSINESS OR INDUSTRY: D. C. Government
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adam Randolph Brady
14. MOTHER'S MAIDEN NAME: Isabelle Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Mr. Randolph G Brady
Address: 100 Kennedy St N. E. Son

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteri-sclerosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite
450.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 30, 1961, to Dec 24, 1961, that I last saw the deceased alive on Dec. 23, 1961, and that death occurred at 11 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. B. Little M.D. 6911 5th St. NW
ADDRESS (Street, city or town, state) DATE SIGNED
PHYSICIAN'S NAME (Type): A. B. LITTLE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL.
22b. DATE THEREOF: 12/27/61
22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cem
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. K. Huntemann
W.K. HUNTEMANN & SON. ADDRESS: 5732 GEORGIA AVE. N.W.
24a. REC'D BY REGISTRAR DATE: DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14064 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14032

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Va.
b. COUNTY: Arlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 3730- N. Pershing Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert; Middle: A.; Last: Breakey

4. DATE OF DEATH: Month: Dec.; Day: 13; Year: 19 61

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb. 22, 1896

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economist (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Gov't

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Abner Breakey

14. MOTHER'S MAIDEN NAME: Mary Lantz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give wars or dates of service): World War 1

16. SOCIAL SECURITY NO.: ----

17. INFORMANT: Daisy M. Breakey/ same as above. Address:

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Exsanguination	sudden
DUE TO (b)	Rupture of thoracic aorta	sudden
DUE TO (c)	Arteri sclerotic aneurysm	? "

451 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. Broschart

Address (Street, city, town, or county):

DATE SIGNED: 12-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 12/18/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem.

22d. LOCATION (City, town, or country) (State): Ft. Myer, Va.

23. FUNERAL DIRECTOR: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: DEC 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14065 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14033

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 32 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X 3
d. STREET ADDRESS: 1226 D Street N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: O TIS — Middle: — Last: BROOKS

4. DATE OF DEATH: Month: Dec. — Day: 20 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/7/22
9. AGE (In years last birthday): 39 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Kraft Murphy Cons. Co
11. BIRTHPLACE (State or foreign country): SOUTH CAROLINA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUDREY BROOKS
14. MOTHER'S MAIDEN NAME: FLOSSIE LONDON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): NAVY
16. SOCIAL SECURITY NO.: 238-20-7569
17. INFORMANT: Hospital record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration
DUE TO (b) Fracture of skull
DUE TO (c) fall

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 34 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Working on construction job and fell 40 feet from scaffold to concrete floor.
20c. TIME OF INJURY: Hour ~~a.m.~~ 1:30 p.m. — Month, Day, Year: 12/19 19 61
20d. INJURY OCCURRED: While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): 10201 Georgia Ave.
20f. (City or town): Silver Spring — (County): Mont. — (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.
EXAMINER'S NAME (Type): Frank J Brochart
Address (Street, city, town, or county):
DATE SIGNED: 12/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): 12/24/61
22b. DATE THEREOF
22c. NAME OF CEMETERY OR CREMATORY: N.G.
22d. LOCATION (City, town, or country): Kings Mountain (State): N.C.

23. FUNERAL DIRECTOR: R.N. HORTON CO. — ADDRESS: 1324 U.S.1
24a. REC'D BY REGISTRAR — DATE: DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14066 14034

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 193 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: R.D.#3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Regina — Middle: Gabrielle — Last: Brown

4. DATE OF DEATH: Month: December — Day: 23, — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 18, 1943
9. AGE (In years last birthday): 18 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Brown
14. MOTHER'S MAIDEN NAME: Regina M. Goss

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) GRam negative septicemia — INTERVAL BETWEEN ONSET AND DEATH: 5 Days
204.3
DUE TO (b) Gastro- intestinal ulceration — 7 Days
DUE TO (c) Acute myelogenous leukemia — 9 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Serum hepatitis, drug hepatitis, gastro-intestinal hemorrhage, bacterial pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 13, 19 61 to December 23, 19 61 that (I) (we) last saw the deceased alive on December 23, 19 61 and that death occured at 2:00 PM from the causes and on the date stated above.

22a. SIGNATURE: Thorne S. Winter, III M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-23-61
22c. PHYSICIAN'S NAME (Type): Thorne S. Winter, III, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/61
23c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery
23d. LOCATION (City, town or county) (State): Chestertown, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Marvin V. Williams — ADDRESS: Chestertown, Md.
25a. REC'D BY REGISTRAR: DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kious

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14067 **CERTIFICATE OF DEATH** 14035

1. PLACE OF DEATH
a. COUNTY: Montgomery, MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 Mo + 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi 1657-2
d. STREET ADDRESS: 1415 Ruatan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Rose Middle: MARY Last: Bunt

4. DATE OF DEATH Month: Dec. Day: 8 Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☑

8. DATE OF BIRTH: MAR. 7-1907

9. AGE (In years last birthday): 54 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Ernest Bodeker

14. MOTHER'S MAIDEN NAME: Minnie Piper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give were or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b) Chronic renal disease — unknown

DUE TO (c) Diabetes mellitus — 15 years

260 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 17, 1961, to Dec. 8, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 7, 1961, and that death occured at 7:00 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Eino Magi, M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-8-61

22c. PHYSICIAN'S NAME (Type): EINO MAGI

22d. ADDRESS: 918 University Blvd. E, Silv. Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 11, 1961

23c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery

23d. LOCATION (City, town or county) (State): Prince George County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters, ADDRESS: 254 Carroll St NW DC

25a. REC'D BY REGISTRAR DATE: DEC 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14068 **CERTIFICATE OF DEATH** 14036

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksville 13X-2
d. STREET ADDRESS: Hallship Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas Middle: Frank Last: Butler
4. DATE OF DEATH: Month 12 Day 30 Year 1961
5. SEX: male
6. COLOR OR RACE: colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1880 [redacted] 81 [redacted] Yrs.
9. AGE (In years last birthday): IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemp.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No
16. SOCIAL SECURITY NO.: 218-32-3334
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 months
4200
DUE TO (b) Aretriosclerotic heart disease — 20 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Nephrosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Sept. 18, 1961 to Dec. 30, 1961, that (I) last saw the deceased alive on Dec. 30, 1961, and that death occured at 8 P.M, from the causes and on the date stated above.

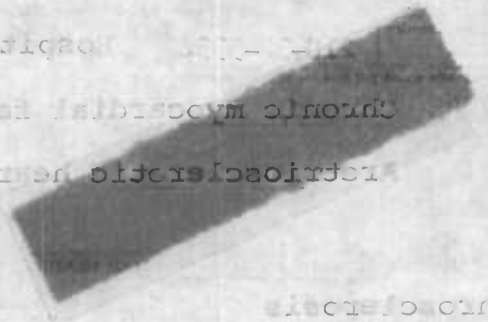
22a. SIGNATURE: C.S. Whitaker, M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-31-61
22c. PHYSICIAN'S NAME (Type): Dr. C.S. Whitaker
22d. ADDRESS: Clarksville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-2-1962
23c. NAME OF CEMETERY OR CREMATORY: Bushy Park
23d. LOCATION (City, town or county) (State): Glenwood, Md

24 FUNERAL DIRECTOR'S SIGNATURE: F.C. HIginbothom, Ellicott City, Md — ADDRESS
25a. REC'D BY REGISTRAR DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14069 14037

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Bethesda~~ Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens San.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Bethesda
d. STREET ADDRESS: 4405 East-West Highway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henrietta Middle: Kibble Last: Carrick
4. DATE OF DEATH: Month: December Day: 6 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 6, 1880
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months 1 Days 0 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: --------
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Alexandria Kibble
14. MOTHER'S MAIDEN NAME: Elizabeth (Unknown)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 578-30-6117B
17. INFORMANT: Elmer Carrick-Husband-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO (b) Cerebral arteriosclerosis. — ?
DUE TO (c)

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Inanition.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ——— 1956 to Dec. 6, 1961 that (I) (~~we~~) last saw the deceased alive on 11-30-1961 and that death occurred at 5:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: George H. Gray, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/6/61
22c. PHYSICIAN'S NAME (Type): GEO. H. GRAY JR. MD.
22d. ADDRESS: 4740 Chevy Chase Dr. Chevy Chase Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/8/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Clifford L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14070 — Reg. Dist. No. 11088

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 22 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 618 - Monroe St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Owen — Middle: V. — Last: Catron
4. DATE OF DEATH: Month: Dec. — Day: 9 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 11, 1900
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Lewis Catron
14. MOTHER'S MAIDEN NAME: L. Anna Dennison
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Ruth Johnson — Address: 1164 Allison St., Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5810

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. / p. m. — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12/6/61, 19, to 12/9/61, 19, that I last saw the deceased alive on 12/9/61, 19, and that death occurred at 8 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John J. Curry M.D. — ADDRESS (Street, city or town, state): 12620 Georgia Ave. Silver Spring Md. — DATE SIGNED: 12/9/61
PHYSICIAN'S NAME (Type): John J. Curry

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/12/61
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 13 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

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2

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

D.O.A. 6 05 pm

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14071 14039

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospi

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Clarksburg Md.
d. STREET ADDRESS: General Delivery
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice Middle: Irene Last: Chase

4. DATE OF DEATH: Month: Dec Day: 17 Year: 1961

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: June 22, 1923

9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maid

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Clarksburg Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marshall Day

14. MOTHER'S MAIDEN NAME: Alice Irene ~~Chase~~ Nason

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: James Chase Husband — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden
501X
DUE TO (b) Pulmonary edema — Sudden
DUE TO (c) Tracheobronchitis, acute — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

Address (Street, city, town, or county):

DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/21/61

22c. NAME OF CEMETERY OR CREMATORY: Rocky Hill.,

22d. LOCATION (City, town, or country) (State): Clarksburg Md.

23. FUNERAL DIRECTOR: Robert L. Snyder — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: DEC 28 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14072 **CERTIFICATE OF DEATH** 14040

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel, 16 X 2
d. STREET ADDRESS: Patuxent Research Refuge,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First / Middle / Last: Clark
4. DATE OF DEATH: Month / Day / Year: December 10, 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 10, 1961
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min. 90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no
10b. KIND OF BUSINESS OR INDUSTRY: no
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Gordon Marston Clark
14. MOTHER'S MAIDEN NAME: Esther Anne Janney
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: no
17. INFORMANT: father Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - 26 wks. gestation — INTERVAL BETWEEN ONset AND DEATH: 90 minutes
776 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Valgene M. Milstead, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/10/61
22c. PHYSICIAN'S NAME (Type): Valgene M. Milstead, M. D.
22d. ADDRESS: 1110 Spring St., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-11-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D. ADDRESS: Washington San. & Hospital
25a. REC'D BY REGISTRAR DATE: DEC 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14073

CERTIFICATE OF DEATH

14041

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
d. STREET ADDRESS: 11516 Georgia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: De Sales — Last: Clark
4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1894
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Man
10b. KIND OF BUSINESS OR INDUSTRY: Wash. Gas Co.
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Frank Albert Clark
14. MOTHER'S MAIDEN NAME: Mary Connolly
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-07-7800A
17. INFORMANT: The Medical Record — Address: Unascertainable The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Carcinoma of the lung with metastasis — 1 year
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (☒ (this hospital) attended the deceased from November 13, 19 61 to December 18 19 61 that (☒ (we) last saw the deceased alive on December 18 19 61 and that death occured at 5:45PM, from the causes and on the date stated above.

22a. SIGNATURE: John C. Marsh M.D.
22b. DATE SIGNED: 12/19/61
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): John C. Marsh, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-21-61
23c. NAME OF CEMETERY OR CREMATORY: Mt Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: F. Collins — ADDRESS: Wash. D.C.
FRANCIS J. COLLINS 3821 14th. St. N. W.
25a. REC'D BY REGISTRAR: DATE DEC 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Burial 12-21-61 Mt Olivet Cemetery Washington D. C.
Wash. D.C.
FRANCIS J. COLLINS 3821 14th. St. N. W.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14074 14042

1. PLACE OF DEATH
e. COUNTY: MONTGOMERY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
e. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 45 BETHESDA
d. STREET ADDRESS: 9409 SINGLETON DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE Middle M Last CLEMENTS

4. DATE OF DEATH: Month Dec. Day 3 Year 19 61

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 6 - 1905
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months 4 Days 27
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Govt
10b. KIND OF BUSINESS OR INDUSTRY: Supervisor.
11. BIRTHPLACE (County & State, or foreign country): Washington DC.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George A Bessler
14. MOTHER'S MAIDEN NAME: Regina A Scott.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.: 579-01-9769
17. INFORMANT: Henry E Clements, Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion & Infarction.
420.1
DUE TO (b): Arterio Sclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchial Asthma.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 11/29, 1961, to date, 19....., that (I) (~~we~~) last saw the deceased alive on 3 Dec 1961, and that death occured at 12:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: John G. Ball M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/3/61
22c. PHYSICIAN'S NAME (Type): John G. Ball
22d. ADDRESS: 7936 Old Georgetown Rd. Beth. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/61
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14075

CERTIFICATE OF DEATH

14043

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Ashton
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Belmont Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Kensington
d. STREET ADDRESS: 4406 Brookfield Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK — Middle STANLEY — Last CONSTABLE

4. DATE OF DEATH: Month Dec. — Day 29 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 4, 1888

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance -DC.Transit

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W.Constable

14. MOTHER'S MAIDEN NAME: Lucy Horsman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.: 578-10-6144A

17. INFORMANT: Mrs.Madeline C.Vierbuchen, Address 4406 Brookfield Dr. Kensington,Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

MEDICAL CERTIFICATION

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	3 hrs
DUE TO (b)	Coronary occlusion	3 hrs
DUE TO (c)	generalized arteriosclerosis	?

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/23/61, 19..., to 12/28/61, 19..., that (I) (we) last saw the deceased alive on 12/28/61, 19..., and that death occured at ...P.M, from the causes and on the date stated above.

22a. SIGNATURE: D Nelson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/28/61

22c. PHYSICIAN'S NAME (Type): Donald Nelson

22d. ADDRESS: 10,620 Georgia Ave.,Silver Spring,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Jan.2,1962

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zissa

ADDRESS: 8434 Ga.Ave.,Silver Spring, Md.

Warner E.Pumphrey,Inc.

25a. REC'D BY REGISTRAR DATE JAN 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14076 **CERTIFICATE OF DEATH** 14044

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville —
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Residence

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3344 22 - Independence St —
d. STREET ADDRESS: Rockville - Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: RUTH Middle: C Last: COOPER.

4. DATE OF DEATH Month: Dec. Day: 31 Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Oct. 18, 1891

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife.

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): New Market - Va -

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rosenberger

14. MOTHER'S MAIDEN NAME: Martha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: 220-09-3336

17. INFORMANT: Lorraine Myers Address: 4422 - Independence St. Rockville - Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO (b): Hypertensive Heart Disease — years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from March, 1958, to Dec. 31, 1961, that (I) (we) last saw the deceased alive on Dec. 31 1961, and that death occured at 11 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1-1-62

22c. PHYSICIAN'S NAME (Type): ABRAHAM W DANISH MD

22d. ADDRESS: 1106 SPRING ST. SILVER SPRING

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: JAN 4. 1962

23c. NAME OF CEMETERY OR CREMATORY: Rockmont Cemetery

23d. LOCATION (City, town or county) (State): Rockville Montg. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur Walters ADDRESS: 254 Carroll St. DC

25a. REC'D BY REGISTRAR DATE JAN 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kimes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14077 14045

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 17
d. STREET ADDRESS: 516 Domer Ave, Apt.# 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Darwin; Middle: (n); Last: CORSA

4. DATE OF DEATH: Month: Dec.; Day: 8; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10 Jan. 1910

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew CORSO

14. MOTHER'S MAIDEN NAME: Laura MATTEA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give war or dates of service): WW II

16. SOCIAL SECURITY NO.: UNK

17. INFORMANT: (W) Edith M. CORSO — Address: Same as #2 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of esophagus
150X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11-10-61, 19..., to 12-8, 19 61, that (I) (we) last saw the deceased alive on 12-8 19 61, and that death occured at 6:A.M, from the causes and on the date stated above.

22a. SIGNATURE: J.W. Brackett Jr., M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-8-61

22c. PHYSICIAN'S NAME (Type): J.W. BRACKETT JR. LT MC USN

22d. ADDRESS: U.S. NAVAL HOSPITAL, BETHESDA, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 12-12-61

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City, town or county) (State): ARLINGTON VIRGINIA

24 FUNERAL DIRECTOR'S SIGNATURE: Douglas Johnson
ADDRESS: RINALDI FUNERAL HOME 7400 GEORGIA AVE, SS, MD.

25a. REC'D BY REGISTRAR DATE: DEC 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Mann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14078

CERTIFICATE OF DEATH

14046

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11121 Newport Mill Road

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Kensington
d. STREET ADDRESS: 11121 Newport Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Carol — Middle: Louis — Last: Cox

4. DATE OF DEATH: Month: December — Day: 16 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 2/21/1887
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months: 9 — Days: 15
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Book seller
10b. KIND OF BUSINESS OR INDUSTRY: Books
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles P. Cox
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 102-28-4973
17. INFORMANT: Robert R. Cox-Son-same 2d — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
DUE TO (b): Recurrent Pleural Effusion — 1 year
DUE TO (c): Chronic Heart Failure - Post Coronary — 2 year

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March, 1961, to 16 Dec, 1961, that (I) (~~we~~) last saw the deceased alive on 16 Dec 1961, and that death occured at 8:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Ann M. Dimitroff, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/16/61
22c. PHYSICIAN'S NAME (Type): Ann M. Dimitroff
22d. ADDRESS: 11300 Woodson Ave — 11300 Woodson Avenue, Kens, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/18/61
23c. NAME OF CEMETERY OR CREMATORY: Wood Lawn Cemetery
23d. LOCATION (City, town or county) (State): New York, New York

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14079

CERTIFICATE OF DEATH

14047

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring
d. STREET ADDRESS: 9214 Mintwood St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Nellie — Middle: Alberta — Last: Cox

4. DATE OF DEATH: Month: 12 — Day: 15 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 2-1-76
9. AGE (In years last birthday): 85 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Taylor
14. MOTHER'S MAIDEN NAME: Tabertha Suttle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Washington Sanitarium + Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT? DUE TO: — MANY YRS.
DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (c)
420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS; ABDOMINAL AORTIC ANEURYSM; CARCINOMA OF BRAIN.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 28, 1961, to Dec. 15, 1961, that (I) (we) last saw the deceased alive on 12-14 1961, and that death occured at 12-15-61 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Dwight R. Smith M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-15-61
22c. PHYSICIAN'S NAME (Type): DWIGHT R. SMITH, M.D.
22d. ADDRESS: 1015 SPRING ST. SILVER SPRING, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-18-61
23c. NAME OF CEMETERY OR CREMATORY: Taylor Mem. Cem
23d. LOCATION (City, town or county) (State): Colonial Beach Va

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga Ave NW Wash DC
25a. REC'D BY REGISTRAR: DATE DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

1
FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14080 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14048

Items 7 & 14 Film G303 12/20/61 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 55 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Silver Spring
d. STREET ADDRESS: 1805 Seeks Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ruth; Middle: Esther; Last: Crum.

4. DATE OF DEATH: Month: Dec; Day: 10; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 9-24-97

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Albright

14. MOTHER'S MAIDEN NAME: Elizabeth unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Pt.'s Chart. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
331X
DUE TO (b) hypertension — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bloschart M.D.
EXAMINER'S NAME (Type): FRANK J. BLOSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 1961

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d. LOCATION (City, town, or country) (State): Frederick, Maryland.

23. FUNERAL DIRECTOR: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. D.C.

24a. REC'D BY REGISTRAR DATE DEC 15 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14081 14049

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 1/2 hr.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San. & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Takoma Park
d. STREET ADDRESS: 8610 Garland Av.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Aaron — Last: Davidoff

4. DATE OF DEATH: Month: 12 — Day: 25 — Year: 1961

5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAR. 31 – 88
9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Shoe mfg.
10b. KIND OF BUSINESS OR INDUSTRY: Shoe business
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Israel Davidoff
14. MOTHER'S MAIDEN NAME: Liebe Lankus

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 028-03-9314
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.1
DUE TO (b): Coronary artery disease — 5 years
DUE TO (c): Coronary arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension and peripheral arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1959 to Dec. 25, 1961, that (I) (we) last saw the deceased alive on Dec. 25, 1961, and that death occured at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Saul Holtzman M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Saul Holtzman
22d. ADDRESS: 1800 Eye St. NW Wash D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/27/61
23c. NAME OF CEMETERY OR CREMATORY: Geo. Washington Cem.
23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Dudley Funeral Home — ADDRESS: 4217-9th NW
25a. REC'D BY REGISTRAR — DATE: DEC 27 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14082 — 14050

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington — 47X·3
d. STREET ADDRESS: 7019 Georgia Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Molly — Middle: Ellen — Last: Davis
4. DATE OF DEATH: Month: Dec. — Day: 26 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 16, 1871
9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Webb
14. MOTHER'S MAIDEN NAME: Eliza Johnson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Louise Kaldenbach — Address: 7019 Ga Ave NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Carcinomatosis of R Lung C — The cancer may have led to a cystic duct
~~DUE TO~~ (b): Metastasis to liver & cystic duct
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ~~DUE TO~~ (c): Recurrent Hydrothorax

163X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10/ 1961 to 12-26 1961, that (I) (we) last saw the deceased alive on 12/26/ 1961, and that death occured at 7:45 p.m., from the causes and on the date stated above.

22a. SIGNATURE: C H Wolthin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Chas H Wolthin
22d. ADDRESS: 7600 Carroll Ave Takoma Park (Md)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-29-61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home — ADDRESS: 4812 Ga Ave NW
25a. REC'D BY REGISTRAR — DATE: JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VR A15 (4)
15M 7/61

Item 18 Film 305
1-12-62 ams

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14083 14051

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Restmor

2. USUAL RESIDENCE (Where decedent lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Bethesda
d. STREET ADDRESS: 8820 River Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: James — Middle: Edward — Last: Day

4. DATE OF DEATH: Month: 12 — Day: 3 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1/30/1887

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardener

10b. KIND OF BUSINESS OR INDUSTRY: Gardening

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Samuel Day

14. MOTHER'S MAIDEN NAME: Rachel Rickett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 578-10-2703

17. INFORMANT: Elsie Day-Wife-same 2d — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 7 days.
DUE TO (b): Undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
053.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Metastatic Carcinoma

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/24, 1961 to 12/3, 1961, that (I) (we) last saw the deceased alive on 12/3, 1961, and that death occured at 7:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Alvin I Kay M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/3/61
22c. PHYSICIAN'S NAME (Type): Alvin I. Kay MD
22d. ADDRESS: 1835 Eye St NW — Wash

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/61
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City, town or county) (State): Silver Spring, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14084 Items 8 & 9 Film G303 12/20/61 iwk 14052

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: One week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 23 Silver Spring
d. STREET ADDRESS: 9301 Ocala St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Johanna — Middle: (YMH) — Last: De Carlo

4. DATE OF DEATH: Month: Dec — Day: 8 — Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: June 21 1886 ~~December 7, 1886~~

9. AGE (In years last birthday): 75 ~~76~~ yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Vincent Jamele

14. MOTHER'S MAIDEN NAME: Mary ~~XXXXXXXXXXXX~~ Jackarosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Nicholas C. DeCarlo — Address: ~~XXXXXXXX~~ 19408 Pine Oak Drive, Silver Spring, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction, acute anterior — INTERVAL BETWEEN ONSET AND DEATH: 7 days
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 15, 1961 to Dec. 8, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 8 1961, and that death occured at 1:55 PM, from the causes and on the date stated above.

22a. SIGNATURE: Raymond Bradshaw, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/61

22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw
22d. ADDRESS: 345 University Blvd W. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN CEMETERY
23d. LOCATION (City, town or county) (State): MONTGOMERY, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond Bizisko
ADDRESS: 8434 GEORGIA AVENUE
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND

25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur J. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14085

CERTIFICATE OF DEATH

14053

1. PLACE OF DEATH
a. COUNTY: Montg — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 77 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Home 18 Maryland Ave

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 07 Gaithersburg
d. STREET ADDRESS: 18 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Herbert — Middle: Laurence — Last: Diamond

4. DATE OF DEATH: Month: Dec — Day: 5th — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 15-1884
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months: 3, Days: 20 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montg. Co. Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John B. Diamond
14. MOTHER'S MAIDEN NAME: Grace Ranney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: John B. Diamond 3rd. — Address: Rockville. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Acute Left Ventricular Heart Failure — 6 hours
420.0
DUE TO
(b) Arteriosclerotic Heart Disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan., 1961 to Dec. 5, 1961, that (I) (we) last saw the deceased alive on 12-5 1961, and that death occured at 2 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-6-61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-7-61
23c. NAME OF CEMETERY OR CREMATORY: St Rose
23d. LOCATION (City, town or county) (State): Gaithersburg. Rural

24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner. — ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR DATE DEC 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14086 14054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL
c. LENGTH OF STAY IN 1b: 35 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia 47X·3
d. STREET ADDRESS: 1107 Alabama Ave., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lida — Middle: May — Last: DICE
4. DATE OF DEATH: Month: December — Day: 5th — Year: 1961

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2 February 1886
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SHERWOOD, Joseph
14. MOTHER'S MAIDEN NAME: FAIRALL, Sarah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: James D. DICE — Address: 1107 Alabama Ave, S.E. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Metastatic carcinoma of breast.
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 24 October, 1961 to 5 December, 1961, that (I) (we) last saw the deceased alive on 5 December 1961, and that death occured at 0015AM from the causes and on the date stated above.

22e. SIGNATURE: Benjamin J. Gilson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: December 5, 1961
22c. PHYSICIAN'S NAME (Type): BENJAMIN J. GILSON LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-8-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Simmons Funeral Home
ADDRESS: Good Hope Rd., S.E. Washington, D.C.
25a. REC'D BY REGISTRAR: DATE DEC 7 '61
25b. REGISTRAR'S SIGNATURE: Orline S. Keane

VR A15 (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14087

CERTIFICATE OF DEATH

Items 2 & 14 ~~XXXX/8302/~~ from birth certificate

14055

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Wheaton
d. STREET ADDRESS: 11935 Andrews Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Boy — Middle: — Last: Dipietro
4. DATE OF DEATH: Month: 12 — Day: 1 — Year: 1961
5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-30-61
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 16 — Min.: 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montgomery Md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Nicholas Di Pietro
14. MOTHER'S MAIDEN NAME: Emma A. Dinnis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTRA Cranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Laceration of Tentorium Cerebelli
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

760.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 30, 1961, to Dec 1, 1961, that (I) (we) last saw the deceased alive on Dec 1 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Shaw-Pearlman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 12-2-61
23c. NAME OF CEMETERY OR CREMATORY: SUBURBAN HOSPITAL
23d. LOCATION (City, town or county) (State): BETHESDA, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: AMELIA C. CARTER, ADMIN. (for FB) — ADDRESS: SUBURBAN HOSP. BETHESDA, MD
25a. REC'D BY REGISTRAR: DATE DEC 5 '61
25b. REGISTRAR'S SIGNATURE: Clinton L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2074375 XV2

1

FOR STATE HEALTH DEPT.

M

I

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14088 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14056

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring (Rural)
d. STREET ADDRESS: rear of 14615 Good Hope Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: E — Last: Dorsey

4. DATE OF DEATH: Month: 12 — Day: 8 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-6-1912

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Garfield Dorsey

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho-pneumonia — ?
002X
DUE TO (b) Chronic Pulmonary Tuberculosis, rt.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonectomy left lung in distant past

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12/8/61

EXAMINER'S NAME (Type): Frank J. Broschart

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 12/14/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National.,

22d. LOCATION (City, town, or country) (State): Arlington, Va.

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR: DATE DEC 14 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14089

CERTIFICATE OF DEATH

14057

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Md.

c. LENGTH OF STAY IN 1b 9 months

d. NAME OF HOSPITAL (If not in hospital, give street address) ~~INSTITUTION~~ Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,

d. STREET ADDRESS ~~8407 Hartford Ave.~~ 824 BONIFANT STREET

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Catherine Middle Nelms Last Downing

4. DATE OF DEATH Month Dec. Day 11 Year 19 61

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Feb. 6, 1870

9. AGE (In years lost birthday) 91 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY OWN HOME

11. BIRTHPLACE (State or foreign country) HEATHSVILLE, VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gustavus Betts

14. MOTHER'S MAIDEN NAME Mary Basye

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ----------

16. SOCIAL SECURITY NO. NONE

17. INFORMANT MR. OSCAR B. DOWNING Address 8407 Hartford ~~XXXX~~ Avenue Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b) MI failure — 3 days

DUE TO (c) bronchopneumonia — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): senility + cachexia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov 13 1960, to 12/11 1961, that (I) (we) last saw the deceased alive on 12/11 1961, and that death occurred at 11 A M, from the causes and on the date stated above.

22a. SIGNATURE Marvin Wadler M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED 12/11/61

22c. PHYSICIAN'S NAME (Type) MARVIN WADLER

22d. ADDRESS 8218 Wisconsin Av Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

23b. DATE THEREOF 12/14/61

23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY

23d. LOCATION (City, town, or county) (State) WASHINGTON D.C.

24. FUNERAL DIRECTOR'S SIGNATURE Stephen E. Pumphrey ADDRESS 8434 GEORGIA AVENUE WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND

25a. REC'D BY REGISTRAR DATE DEC 15 '61

25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

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M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14058

1. PLACE OF DEATH 14090
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rt#1 Gaithersburg, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Mongomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Routel# Gaithersburg, Md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marion — Middle: Frances — Last: Duvall

4. DATE OF DEATH: Month: December — Day: 5 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1934
9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Moore
14. MOTHER'S MAIDEN NAME: Harriett Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Right Ovary.
175.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August, 1961 to Dec 5, 1961, that (I) (we) last saw the deceased alive on Dec. 3 1961, and that death occured at 3:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Luciano I. Ledl M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): Luciano I. Ledl
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/10/61
23c. NAME OF CEMETERY OR CREMATORY: Brooke Grove.,
23d. LOCATION (City, town or county) (State): Laytonsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14091

CERTIFICATE OF DEATH

Reg. Dist. No. 14059

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 3 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: WASH. SANT. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 TAKOMA PARK
d. STREET ADDRESS: 8011 CARROLL ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE Middle C. Last ELLIOTT
4. DATE OF DEATH: Month Dec Day 25 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 3, 1889
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Wash DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Michael Sexton
14. MOTHER'S MAIDEN NAME: McCabe
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-26-2165
17. INFORMANT: Ray Elliott — Address: 9707 Heron Dr Silver Spring Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 60 hrs
420.1
DUE TO (b) Senile Arteriosclerosis — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1951, to 25 Dec, 1961, that I last saw the deceased alive on 25 Dec, 1961, and that death occurred at 6:30 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H B Queen M.D. — ADDRESS (Street, city or town, state): 7112 Willow Ave — DATE SIGNED: 25 Dec 1961

PHYSICIAN'S NAME (Type): H. B. Queen M.D. — Takoma Park Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/28/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: W W Taltavull — ADDRESS: 3603 14th St NW
24a. REC'D BY REGISTRAR: DATE DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14092 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14060

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 1/31/61
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WHEATON NURSING HOME

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: PENNA.
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PLAINS 75X-3
d. STREET ADDRESS: 27 PERKINS ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROBERT — Middle: JOSEPH — Last: ELWARD

4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 61

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: ~~1898~~ 3/5/96

9. AGE (In years last birthday): ~~62~~ 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): PLAINS, PA.

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: THOMAS J. ELWARD

14. MOTHER'S MAIDEN NAME: ELIZABETH LAMB

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: None ~~[illegible]~~

17. INFORMANT — Address: Thomas Elward-Brother-Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: FOUND DEAD IN BED

420.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): HOSTORY OF HYPERTENTION

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-18-61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/19/61

22c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

22d. LOCATION (City, town, or country) (State): Hanover Township, Pa.

23. FUNERAL DIRECTOR — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: DEC 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Mann

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14093

CERTIFICATE OF DEATH

Item 9 Film G503 12/21/61 1wk

14061

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitorium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON 47X-3
d. STREET ADDRESS: 1343 KALMIA ROAD N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rufus; Middle: P.; Last: Embrey

4. DATE OF DEATH: Month: Dec; Day: 7; Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-29-84
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): salesman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Embrey, R. J.
14. MOTHER'S MAIDEN NAME: Savin, Katie

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: LEE ANNA EMBREY — Address: 1343 KALMIA RdNW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH: 4 WEEKS
DUE TO
(b) HYPERTENSIVE AND ARTERIOSCLEROTIC VASCULAR DISEASE — 5 YEARS
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4457X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MARCH 1959 to DECEMBER 7 1961, that (I) (we) last saw the deceased alive on DECEMBER 6 1961, and that death occurred at 12:25 AM, from the causes and on the date stated above.

22a. SIGNATURE: Robert L. Krichmar M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: DECEMBER 7 1961
22c. PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR MD
22d. ADDRESS: 7733 ALASKA AVENUE N.W. WASHINGTON 12 D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-9-61
23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY
23d. LOCATION (City, town, or county) (State): BLADENSBURG, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home, Inc
ADDRESS: 4812 GEORGIA AVE WASHINGTON, D C
25a. REC'D BY REGISTRAR: DATE DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14094

CERTIFICATE OF DEATH

14062

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 409 West Montgomery Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 409 West Montgomery Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Edward — Last: England

4. DATE OF DEATH: Month: Dec. — Day: 10 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 16, 1869
9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months 6, Days 24 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Mail Carrier
10b. KIND OF BUSINESS OR INDUSTRY: Farm Retired
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. England
14. MOTHER'S MAIDEN NAME: Mary E. Hendry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Churchill E. Ward-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

422.1

DUE TO (b): Arteriosclerotic cardiovascular disease — 2 years

DUE TO (c): Senility. (Age 92) — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1955, 19__, to Dec-10, 1961, that (I) (~~was~~) last saw the deceased alive on Dec-10-1961, and that death occured at 3:35 PM from the causes and on the date stated above.

22a. SIGNATURE: Wm A. Linthicum M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/10/61
22c. PHYSICIAN'S NAME (Type): Wm A. Linthicum
22d. ADDRESS: 110 S. Washington St., Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/13/61
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

FOR STATE HEALTH DEPT.

M

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14095 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14063

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montg. Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville
d. STREET ADDRESS: Brookeville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

14 1

3. NAME OF DECEASED (Type or print): First: Marie — Middle: Rosietta — Last: Evans
4. DATE OF DEATH: Month: Dec — Day: 11 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-8-61
9. AGE (In years last birthday): 0 yrs. — IF UNDER 1 YEAR: Months 3, Days 3 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Evans
14. MOTHER'S MAIDEN NAME: Clara Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes give wars or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clara Evans (mother) Address: Ste 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Upper Respiratory Infection
DUE TO (c):

475X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found collapsed in Zoo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-11-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/13/61
22c. NAME OF CEMETERY OR CREMATORY: Round Oak.,
22d. LOCATION (City, town, or country) (State): Spencerville, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: DATE DEC 14 '61
24b. REGISTRAR'S SIGNATURE: Clifton S. Krause

2074205 X V4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14096

CERTIFICATE OF DEATH

14064

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 5 M 75 2 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery (Prince George's)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 1656-2
d. STREET ADDRESS: 8112 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henrietta — Middle: EASTON — Last: Fagan
4. DATE OF DEATH: Month: 12 — Day: 18 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 10-2-85
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James L. Easton
14. MOTHER'S MAIDEN NAME: Mary E Anderson.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT: Brother. (Mr. Wm H. Easton) — Address: Same address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis superior mesenteric artery — INTERVAL BETWEEN ONSET AND DEATH: 1 hour.
DUE TO (b): General arteriosclerosis severe — 4 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
450.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 11/4, 1961 to 12/18, 1961, that ~~(I)~~ (we) last saw the deceased alive on 12/18 1961, and that death occured at 8:30 p.M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Hugh Prey
22d. ADDRESS: 7105 Riggs Rd Lewisdale Hyattsville P.O. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-22-61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county) (State): Wash D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: W W Chambers Co. — ADDRESS: 8655 Ga Ave Sil Spg Md.
25a. RECD BY REGISTRAR — DATE: DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A1S (4)
15M 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14097 14065

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 57 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. ~~XXXX~~ Country: Tunisia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tunis
d. STREET ADDRESS: No Street Address
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

15X-1

50

3. NAME OF DECEASED (Type or print): First: Ibrahim; Middle: None; Last: Fanon
4. DATE OF DEATH: Month: December; Day: 6; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 20, 1925
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician
10b. KIND OF BUSINESS OR INDUSTRY: Medical
11. BIRTHPLACE (County & State, or foreign country): West Indies
12. CITIZEN OF WHAT COUNTRY? Algeria
13. FATHER'S NAME: Casimir Fanon
14. MOTHER'S MAIDEN NAME: Eleanora Medlice
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia with Pulmonary Congestion Bilateral. Pleural Effusion, Bilateral. — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
(b) Acute Myelogenous Leukemia — 10 Weeks
DUE TO
(c)

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 10, 1961 to December 6, 1961, that (I) (we) last saw the deceased alive on December 6, 1961, and that death occured 3:00pm from the causes and on the date stated above.

22a. SIGNATURE: J David Heywood M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-7-61
22c. PHYSICIAN'S NAME (Type): J. David Heywood, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/9/61
23c. NAME OF CEMETERY OR CREMATORY: Algerian Mission
23d. LOCATION (City, town or county) (State): 16 Rue duDrBrunet, Tunis

24 FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 3

FOR STATE HEALTH DEPT.

M 99 I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14098 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14066

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 16 Silver Spring, Maryland
d. STREET ADDRESS: 202 Southampton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mr. Alexander; Middle: Gordon; Last: Fant

4. DATE OF DEATH: Month: December; Day: 19; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12, 1912

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Drug Clerk

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alexander John Fant

14. MOTHER'S MAIDEN NAME: Helen ~~Schroat~~ HARENBERG

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: RUTH L FANT — Address: 202 S. Hampton Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-19-61

EXAMINER'S NAME (Type): FRANK J. Broschart

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-21-61

22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery

22d. LOCATION (City, town, or country) (State): Washington, D. C.

23. FUNERAL DIRECTOR: Deal Funeral Home — ADDRESS: 4812 Ga.Ave., N.W., Wash.DC

24a. REC'D BY REGISTRAR: DATE: DEC 21 '61

24b. REGISTRAR'S SIGNATURE: Clifton E. Kruse

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14099 **CERTIFICATE OF DEATH** 14067

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 75 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Norfolk
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norfolk
d. STREET ADDRESS: 1330 Monterey Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83-3

3. NAME OF DECEASED (Type or print): First NANCY — Middle ANN — Last FARLEY
4. DATE OF DEATH: Month December — Day 11 — Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: September 26, 1934
9. AGE (In years last birthday): 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Secretarial
11. BIRTHPLACE (County & State, or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Spencer E. Kipp
14. MOTHER'S MAIDEN NAME: Erma Staggs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 229-42-4873
17. INFORMANT: The Medical Record, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 13 hours
DUE TO (b) Hypoplastic Anemia — 10 months
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

273 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept. 27, 1961, to December 11, 1961, that (I) (we) last saw the deceased alive on Dec. 11, 1961, and that death occured at 12:25pm, from the causes and on the date stated above.

22a. SIGNATURE: Russell R. Moores M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-12-61
22c. PHYSICIAN'S NAME (Type): RUSSELL R. MOORES, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. ~~BURIAL~~, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: 12-12-61
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town or county) (State): Norfolk, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: J. Wm. Tolles — ADDRESS: Wash. D.C.
25a. REC'D BY REGISTRAR — DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14100

Reg. Dist. No. 1068

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Charles Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rockville
d. STREET ADDRESS 106 Charles Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: CHARLES Middle: WILLIAM Last: FAWLEY, Sr.

4. DATE OF DEATH Month: Dec. Day: 16, Year: 1961

5. SEX Male

6. COLOR OR RACE White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH Sept. 10, 1879

9. AGE (In years last birthday) 82 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Farmer

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William B. Fawley

14. MOTHER'S MAIDEN NAME Margaret A. Wright

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-26-6841

INFORMANT Robert B. Fawley-Item# 2 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS.
DUE TO
(b) ARTERIOSCLEROTIC HEART DISEASE — 10 YRS.
DUE TO
(c)

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12-16, 1961, to 12-16, 1961, that I last saw the deceased alive on 12-16, 1961, and that death occurred at 7:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE W. G. Hall M.D. **ADDRESS** (Street, city or town, state) 615 W. Montg. Ave. Rockville, Md. **DATE SIGNED** 12/16/61

PHYSICIAN'S NAME (Type) W.G. Hall 615 W. Montg. Ave., Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 12/19/61

22c. NAME OF CEMETERY OR CREMATORY Monocacy

22d. LOCATION (City, town, or county) (State) Beallsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

24a. REC'D BY REGISTRAR DATE DEC 20 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14069

Items 9 & 23b Film G304 12/29/61 mh

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH: MONTGOMERY COUNTY 14101 — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA (RURAL)
c. LENGTH OF STAY IN 1b: 4MO 26da
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: N. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TARAWA TARRACE 70X·3
d. STREET ADDRESS: 3389 HAGARU DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPHINE Middle PATRICA Last FELLOWS
4. DATE OF DEATH: Month DECEMBER Day 16 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 DECEMBER 1911
9. AGE (In years last birthday): ~~49~~ 50 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): ILLINOIS
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: WALTER WALSH
14. MOTHER'S MAIDEN NAME: HELENE PORZEL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband: Robert Fellows, same as #3 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	Pneumonia - Asphyxiation	
DUE TO (b)	Metastatic Carcinoma of Cervix	2 yrs
DUE TO (c)	General Debilitation	4 months

171X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JULY 20, 1961 to DECEMBER 16 1961, that (I) (we) last saw the deceased alive on DEC. 16 1961, and that death occured at 0640, from the causes and on the date stated above.

22a. SIGNATURE: Louis E. Potvin M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-16-61
22c. PHYSICIAN'S NAME (Type): LOUIS E. POTVIN, LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 21, 1961
23c. NAME OF CEMETERY OR CREMATORY: St. Boniface Cemetery
23d. LOCATION (City, town or county) (State): Chicago, Ill.
24. FUNERAL DIRECTOR'S SIGNATURE: Robert H. Pumphrey
ADDRESS: ROBERT A. PUMPHREY Funeral Home, Bethesda, Md.
25a. REC'D BY REGISTRAR DATE DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Andrew J. Kirwin

VR A1S (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14102

CERTIFICATE OF DEATH

14070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14hrs-10min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Takoma Park
d. STREET ADDRESS: 6506 Highland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Allen — Last: Fielding

4. DATE OF DEATH: Month: December — Day: 3 — Year: 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: October 14, 1904
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plasterer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Fielding
14. MOTHER'S MAIDEN NAME: Sallie Bailey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 578-01-7983
17. INFORMANT: Hospital Record. — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

162.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb, 1961 to Dec 3, 1961 that (I) (we) last saw the deceased alive on Dec 3 1961 and that death occured at 11:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: Boris Rabkin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: December 4, 1961
22c. PHYSICIAN'S NAME (Type): BORIS RABKIN, M.D.
22d. ADDRESS: 1019 University Blvd, East Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 6, 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St NW DC
25a. REC'D BY REGISTRAR DATE: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14103 **CERTIFICATE OF DEATH** 14071

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9819 Rosensteel Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clyde Middle: William Last: Fiery
4. DATE OF DEATH: Month: Dec. Day: 10 Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/9/83
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical engineer
10b. KIND OF BUSINESS OR INDUSTRY: Govt.
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Albert Fiery
14. MOTHER'S MAIDEN NAME: Kathryn ? Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Elizabeth Fiery Address: 9819 Rosensteel Ave. Silver Sp.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Myocardial hypertrophy
DUE TO
(c): Generalized atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May, 1955, to 12-10, 1961, that (I) ~~(we)~~ last saw the deceased alive on 12-9 1961, and that death occured at 1:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Seruth T. Kimble M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Seruth T. Kimble
22d. ADDRESS: 927 Pershing Drive Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/13/61
23c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Zisk ADDRESS: 8434 GEORGIA AVENUE
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND
25a. REC'D BY REGISTRAR DATE DEC 14 '61
25b. REGISTRAR'S SIGNATURE: Clifford L. Kinne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14104 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14072

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Silver Sping
d. STREET ADDRESS: 1 2100 Reddie Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Francis; Middle:; Last: Figelman
4. DATE OF DEATH: Month: December; Day: 8; Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/6/07
9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months: ; Days: IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economist
10b. KIND OF BUSINESS OR INDUSTRY: Bureau of Foreign Commerce
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Figelman
14. MOTHER'S MAIDEN NAME: Ethel Cohen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: 218389519
17. INFORMANT: Sophie Figelman — Address: 2100 Reedie Dr., SS, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO
(b) Thrombosis, left coronary artery — Sudden
DUE TO
(c) Coronary Atherosclerosis — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-8-61
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-10-61
22c. NAME OF CEMETERY OR CREMATORY: New Montefiore Cem.
22d. LOCATION (City, town, or country) (State): Pinelawn, New York

23. FUNERAL DIRECTOR: Bernard Danzansky & Sons — ADDRESS: 3501 14th St. NW
24a. REC'D BY REGISTRAR DATE: DEC 11 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M 99 I 2 2

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14105

CERTIFICATE OF DEATH

14073

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville,
d. STREET ADDRESS: 200 ~~S~~ Horners Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RAYMOND Middle: CLAY Last: FISHER

4. DATE OF DEATH: Month: 12- Day: 22 Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-24-05

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): service sta. attendant

10b. KIND OF BUSINESS OR INDUSTRY: oil

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Nathaniel Clay Fisher

14. MOTHER'S MAIDEN NAME: Cora Mc Gaha

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~Unknown~~ No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 217-03-4612

17. INFORMANT: Hospital records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 30 HOURS
DUE TO
(b) ARTERIOSCLEROSIS — 10 YEARS
DUE TO
(c) ARTERIAL HYPERTENSION — 10 YEARS

331X

Conditions, if any, which geva rise to immediate ceuse (a), stating the underlying ceusa lest.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NEPHROSCLEROSIS - RENAL FAILURE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 21 DEC, 1961 to 22 DEC, 1961 that (I) ~~(we)~~ last saw the deceased alive on 22 DEC 1961, and that death occured 8 AM, from the causes and on the date stated above.

22a. SIGNATURE: Gordon S Rosenberger M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 22 Dec 1961

22c. PHYSICIAN'S NAME (Type): Gordon S. Rosenberger

22d. ADDRESS: 310 W. Montgomery Ave Rockville, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/26/61

23c. NAME OF CEMETERY OR CREMATORY: Potomac Meth. Ch. Cem.

23d. LOCATION (City, town or county) (State): Potomac, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14105

CERTIFICATE OF DEATH

14074

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 721 Thayer Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 721 Thayer Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Howard; Middle: Sturdevant; Last: Fisk
4. DATE OF DEATH: Month: December; Day: 20; Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/1/78
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Star Newspaper Reporter
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New York City
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Henry Clay Fisk
14. MOTHER'S MAIDEN NAME: Emma Jane Nutt
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Katherine Fisk Bartley — Address: same as #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 month
420.1
DUE TO (b): ARTERIOSCLEROSIS — Unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from November 16 1961, to December 20 1961, that (I) (~~we~~) last saw the deceased alive on December 18 1961, and that death occured at 1:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: Theodore J. Abernethy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Theodore J. Abernethy
22d. ADDRESS: 1834 Eye St. N.W. Washington 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 12/22/61
23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Company
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14107 **CERTIFICATE OF DEATH** 14075

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 16 da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Alta Vista Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 54
d. STREET ADDRESS: 4111 Leland st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Richard Middle: Wilson Last: Flournoy

4. DATE OF DEATH Month: Dec. Day: 6 Year: 1961

5. SEX: M **6. COLOR OR RACE**: W **7. MARRIED** ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 20th 1878 **9. AGE** (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Park Flournoy
14. MOTHER'S MAIDEN NAME: Mary Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Addison H. Flournoy Address: 4111 Leland st. Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Instant
434.4
DUE TO (b): Cardiac Irregularity — 30 days
DUE TO (c): Old Age

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE DETERMINED

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Jan 19 40 to Dec 6, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec 5 1961 and that death occurred at 11:15 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Bradley D Hodgkins M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 6, 1961
22c. PHYSICIAN'S NAME (Type): BRADLEY D. HODGKINS
22d. ADDRESS: 4413 Bradley Lane

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14108

CERTIFICATE OF DEATH

Reg. Dist. No. 14076

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park Md.
c. LENGTH OF STAY IN 1b: 28 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Wash. San and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X.3
d. STREET ADDRESS: 6010 Broad Branch Rd. NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn Middle: Susan Last: Foresman

4. DATE OF DEATH: Month: 12 Day: 19 Year: 1961

5. SEX: Fe
6. COLOR OR RACE: wh.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-9-98
9. AGE (In years lost birthday): 63 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Economist
10b. KIND OF BUSINESS OR INDUSTRY: Mgr. cafeterias
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Bond
14. MOTHER'S MAIDEN NAME: Cordelia Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ?
INFORMANT: Hospital chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSE BY:
IMMEDIATE CAUSE (a) Acute Cardiac Dilatation - Rt Hrt Failure — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO
(b) Congestive Cardiac Failure — 3 weeks
DUE TO
(c) Hypertensive Cardio-Renal Complex — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

442X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 11-19-, 1961, to 12-19, 1961, that I last saw the deceased alive on Dec 18, 1961, and that death occurred at 7:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare, M.D. — ADDRESS (Street, city or town, state): 7600 Carroll Ave, Takoma Park, Md. — DATE SIGNED: 12/19/61

PHYSICIAN'S NAME (Type): Robert A. Hare, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 12/22/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cem. - Arlington, Virginia
22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co., 2901 14th St., N.W. — ADDRESS: Wash. D.C.
24a. REC'D BY REGISTRAR DATE: DEC 22 '61
24b. REGISTRAR'S SIGNATURE: Esther L. Hines

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14109 **CERTIFICATE OF DEATH** 14077

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Derwood,
d. STREET ADDRESS: Box 66
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ALFRED Middle: LLOYD Last: FRALEY

4. DATE OF DEATH: Month 12 Day 7 Year 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8-26-93
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (RETIRED) MECHINIST
10b. KIND OF BUSINESS OR INDUSTRY: Garage
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Fraley
14. MOTHER'S MAIDEN NAME: Hinda Adamson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no ~~unk.~~ (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA.
DUE TO
(b) ADENOCARCINOMA OF STOMACH WITH METASTASIS TO
DUE TO
(c) THE DIAPHRAGM.

15/X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -
20c. TIME OF INJURY Hour a.m. p.m. - Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/5/60 to 12/7/61, that (I) (we) last saw the deceased alive on 12/7/61, and that death occured at 8:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/61
22c. PHYSICIAN'S NAME (Type): C. H. LIGON, M.D.
22d. ADDRESS: SANDY SPRING, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-11-61
23c. NAME OF CEMETERY OR CREMATORY: St. Luke's Lutheran
23d. LOCATION (City, town or county) (State): Redland Mont. Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber ADDRESS: Laytonsville, Maryland
25a. REC'D BY REGISTRAR DATE DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

(M)

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14110 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14078

M

X

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: 10 min.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 8 Russell Ave., Drs. office

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg (rural)
d. STREET ADDRESS: Metropolitan Grove
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: F — Last: Frazier

4. DATE OF DEATH: Month: Dec. — Day: 4 — Year: 1961

5. SEX: male
6. COLOR OR RACE: col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/ 12/1899
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Cy Frazier
14. MOTHER'S MAIDEN NAME: Mary Noland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: M.C. Police — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage
DUE TO (b) Rupture of aortic aneurysm into
DUE TO (c) large bronchus of lung st

022X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12/5/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/9/61
22c. NAME OF CEMETERY OR CREMATORY: St. Rose.,
22d. LOCATION (City, town, or county) (State): Cloppers, Md.

23. FUNERAL DIRECTOR: Robert L. Snowden — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR — DATE: DEC 14 '61
24b. REGISTRAR'S SIGNATURE: Carlton S. Hanna

2

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1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14111 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14079

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Kensington
d. STREET ADDRESS: 1 5209 Gretchen St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Deborah Middle Lynn. Last Gabriel

4. DATE OF DEATH: Month December Day 21, Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/7/58
9. AGE (In years last birthday): 3 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roger P. Gabriel
14. MOTHER'S MAIDEN NAME: Barbara Trunnell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): —
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Harp Russell Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs.
DUE TO (b): 1st, 2nd & 3rd degree burns involving about 80% of body
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes caught afire - playing with cigarette lighter
20c. TIME OF INJURY Hour e.m. 9:12 p.m. Month, Day, Year 12-21 1961
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Kensington (County): Montg. (State): Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 12-21-61
Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-23-1961
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country): Rockville, Md. (State):

23. FUNERAL DIRECTOR: Joseph Gaudis Sons, Inc. ADDRESS: 1756 Pa. Ave. N.W. Washington, D.C.
24a. REC'D BY REGISTRAR DATE DEC 26 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14112 **CERTIFICATE OF DEATH** 14080

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b: 15 mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 16550 Emory Lane.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MD.
b. COUNTY: Montg
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 16550 Emory Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JESSIE Middle LORETTA Last GAUL
4. DATE OF DEATH: Month December Day 22 Year 19 61
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 16, 1879
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (County & State, or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William James Morrison
14. MOTHER'S MAIDEN NAME: Ellen O'Brien
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs Katherine Mather — Address: 16550 Emory La. Rockville

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
450.0
DUE TO (b): Arteriosclerosis, Generalized — 4 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 19 61, to 12/22 19 61, that (I) (we) last saw the deceased alive on 12/22 19 61, and that death occured at ... A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/22/61
22c. PHYSICIAN'S NAME (Type): C. H. Lyon MD
22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE THEREOF: Dec. 26 1961
23c. NAME OF CEMETERY OR CREMATORY: Maple Grove Park
23d. LOCATION (City, town or county) (State): Hackansack New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Maryland
25a. REC'D BY REGISTRAR DATE DEC 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14113 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14081

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 hour 40 min.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 14105 Chelmsford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: NMN; Last: Geatt
4. DATE OF DEATH: Month: December; Day: 31; Year: 1961
5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 30, 1923
9. AGE (In years last birthday): 38 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Philadelphia Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Morris Brenner
14. MOTHER'S MAIDEN NAME: REBECCA —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Washington Sanitarium + Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

429.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: JAN 2-1962
22c. NAME OF CEMETERY OR CREMATORY: MONTEFIORE CEM
22d. LOCATION (City, town, or country) (State): MONTGOMERY Co PENN

23. FUNERAL DIRECTOR: B Dangansky & Sons
ADDRESS: 3501-14th St NW
24a. REC'D BY REGISTRAR: DATE JAN 4 '62
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 0305 1/8/62 mh

14114

CERTIFICATE OF DEATH

Reg. Dist. No. 14082

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bel Pre Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Silver Spring Bethesda
d. STREET ADDRESS: 5000 Aberdeen Rd. ~~Bel Pre Nursing Home~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: SIMON; Middle:; Last: GERBER

4. DATE OF DEATH: Month: December; Day: 31; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Apr. 6, 1882

9. AGE (In years lost birthday): 79 yrs.

IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist-Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

INFORMANT: Maurice B. Miller
Address: 8000 Aberdeen Road Bethesda, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
(b) Arteriosclerotic Heart Disease — 1 8 months
DUE TO
(c)

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Arteriosclerosis

0

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/19, 1961, to 12/31, 1961, that I last saw the deceased alive on 12/30, 1961, and that death occurred at 6 45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Irving W. Winik **M.D.** **ADDRESS** (Street, city or town, state): 3900 McKinley St. NW **DATE SIGNED**: 12/31/61

PHYSICIAN'S NAME (Type): Irving W. Winik

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Jan. 2, 1962

22c. NAME OF CEMETERY ~~OR CREMATORY~~: King David Memorial Garden

22d. LOCATION (City, town, or county) (State): Falls Church, Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Bernard Danzansky & Sons 3501 14th St. NW

24a. REC'D BY REGISTRAR DATE: JAN 4 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14083

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 56 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cabin John
d. STREET ADDRESS: 6912 Seven Locks Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence; Middle: E; Last: Gibbs
4. DATE OF DEATH: Month: 12; Day: 12; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-15-1902
9. AGE (In years last birthday): 59 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: EDWARD GIBBS
14. MOTHER'S MAIDEN NAME: Odelia JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-01-8195
17. INFORMANT: Hosp. Record Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1½ hr.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 12-13-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/16/1961
22c. NAME OF CEMETERY OR CREMATORY: Moses Cemetery
22d. LOCATION (City, town, or country) (State): Cabin John, Maryland

23. FUNERAL DIRECTOR: John R. Asher ADDRESS: 653 W. Ernest Jarvis Co., Inc. 1432 You Street, N.W.
24a. REG'D BY REGISTRAR: DEC 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14116

CERTIFICATE OF DEATH

14084

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 704 Gilbert Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter Middle: William Last: Girton
4. DATE OF DEATH: Month: December Day: 15 Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 5, 1909
9. AGE (In years last birthday): 52 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Yard clerk
10b. KIND OF BUSINESS OR INDUSTRY: Wash. Sub. Sanitary Commission
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry R. Girton
14. MOTHER'S MAIDEN NAME: Dora Simmons

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Yes, UN
17. INFORMANT: Washington Sanitarium and Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung c̄ metastases — INTERVAL BETWEEN ONSET AND DEATH: 5 wk.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 5, 1961, to Dec. 15, 1961, that (I) (we) last saw the deceased alive on Dec. 14, 1961, and that death occured at 6:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: A W Dalish M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-15-61
22c. PHYSICIAN'S NAME (Type): ABRAHAM W DALISH
22d. ADDRESS: 1106 Spring St. Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 18, 1961
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Dec. — ADDRESS: 8655 Ga. Ave. Silver Spring, Md
25a. REC'D BY REGISTRAR: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14117 **CERTIFICATE OF DEATH** 14085

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 35 Kensington
d. STREET ADDRESS: 3822 Lawrence Ave,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha; Middle: A; Last: Gittings

4. DATE OF DEATH: Month: Dec.; Day: 24,; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 3, 1890

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James A. Gordon

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Melvin Roderick(son) Address: 3809 Decatur Ave. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rt. failure c shock — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.
420.0
DUE TO (b) Arteriosclerotic H disease — sev. yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12/23, 1961, to 12/24, 1961, that (I) (~~we~~) last saw the deceased alive on 12/24 1961, and that death occured at 1:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Marvin Wadler M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): MARVIN WADLER

22d. ADDRESS: 8218 WISCONSIN Av. BETH. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-27-61

23c. NAME OF CEMETERY OR CREMATORY: Brownsville Cemetery

23d. LOCATION (City, town or county) (State): Brownsville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY

ADDRESS: Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: DEC 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14118 **CERTIFICATE OF DEATH** 14086

1. PLACE OF DEATH
e. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 6½ hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Wheaton
d. STREET ADDRESS: 1407 Wheaton Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clarence Middle: McKinley Last: Green

4. DATE OF DEATH Month: Dec Day: 19 Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Feb 10 1917

9. AGE (In years last birthday): 44 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fugeson Green

14. MOTHER'S MAIDEN NAME: Earlice Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): World War II

16. SOCIAL SECURITY NO.:

17. INFORMANT: Estelle Jane Green (wife) Address: 4013 Plyers Mill Rd Kensington Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Respiratory insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1 hour?
527.2
DUE TO (b): Pulmonary Edema — ?
DUE TO (c): Mucoid obstruction of Bronchi

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/18/61, 19..., to 12/19/61, 19..., that (I) (we) last saw the deceased alive on 12/19/61, 19..., and that death occured at 12:AM, from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Witowski Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/61.
22c. PHYSICIAN'S NAME (Type): Edward S. Witowski, Jr.
22d. ADDRESS: SUITE 400, 8218 WISCONSIN AVE. BETHESDA 14, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington, National.,
23d. LOCATION (City, town or county) (State): Arlington, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Brandenburg
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR DATE: DEC 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14119 14087

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 53 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg, X
d. STREET ADDRESS: Rt . Box226 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Francis Charles Green; Middle; Last
4. DATE OF DEATH: Month 12; Day 2; Year 1961

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 1/28/1889
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Irvin Green
14. MOTHER'S MAIDEN NAME: Harriett Lafsnider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARTION — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b) CORONARY ARTERIOSCLEROSIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10-10, 1961 to 12-2, 1961, that (I) (we) last saw the deceased alive on 12-2 1961, and that death occurred at 6:45 p.M, from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12-3-61
22c. PHYSICIAN'S NAME (Type): Jack Schumacher
22d. ADDRESS: Gaithersburg. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-4-61
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d. LOCATION (City, town or county) (State): Bladensburg. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner — ADDRESS: Gaithersburg. Md.
25a. REC'D BY REGISTRAR — DATE: DEC 5 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
15M 9/60

ACUTE MYOCARDIAL INFARTION
CORONARY ATHEROSCLEROSIS

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14120 **CERTIFICATE OF DEATH** Information from Hosp. Cert. 14088

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X·3
d. STREET ADDRESS: 3704 Macomb Street NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant — Middle: James Edward — Last: Greene
4. DATE OF DEATH: Month: Dec — Day: 13 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: Dec. 13 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 3 — Min.: 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: John William ~~(Unknown)~~ Greene
14. MOTHER'S MAIDEN NAME: Nattalie Patricia Griffith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: (Hospital Record.) Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH
760.0
DUE TO (b): Subarachnoidal hemorrhage
DUE TO (c): Birth trauma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 13 Dec, 1961 to 13 Dec, 1961, that (I) (we) last saw the deceased alive on 13 Dec 1961, and that death occured at 1630 PM from the causes and on the date stated above.

22a. SIGNATURE: RH Mitchell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 18 Dec 61
22c. PHYSICIAN'S NAME (Type): RH MITCHELL MD
22d. ADDRESS: 8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-26-61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14121 14089

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4821 Flanders Avenue
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Victoria Middle: (No middle name) Last: Gruver
4. DATE OF DEATH: Month: December Day: 24 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 5 April 1894
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Daniel Gruver
14. MOTHER'S MAIDEN NAME: Katherine Schnee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Not available
17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST — INTERVAL BETWEEN ONSET AND DEATH: 5 MIN
DUE TO (b) OSTEOGENIC SARCOMA WITH — 6 MONTHS
DUE TO (c) PULMONARY METASTASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from December 15, 1961, to December 24 19 61 that I (we) last saw the deceased alive on December 24 19 61, and that death occured at 7:15 P M, from the causes and on the date stated above.

22a. SIGNATURE: J. Kent Trinkle M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: December 25, 1961
22c. PHYSICIAN'S NAME (Type): J. Kent Trinkle, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 12-25-61
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery
23d. LOCATION (City, town or county) (State): Hanover Township, Penna.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14122 **CERTIFICATE OF DEATH** 14090

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: NB
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Rockville
d. STREET ADDRESS: 1231 Gladstone Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: LISA Middle: MARIE Last: GUARDINO

4. DATE OF DEATH Month: December Day: 7 Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: DEC 6, 1961

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months: Days: 1 IF UNDER 24 HRS.: Hours: — Min.: 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: JOSEPH JOHN GUARDINO

14. MOTHER'S MAIDEN NAME: MAUREEN AGNES CLARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT Address: MOTHER

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): bronchopn

763.5

DUE TO (b): prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/6, 1961, to 12/7, 1961, that (I) (we) last saw the deceased alive on 12/7 8:30 AM 1961, and that death occured at 12:20 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Vita R Saffe M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/7/61

22c. PHYSICIAN'S NAME (Type): SAFFE, Vita R

22d. ADDRESS: 5079 Bradley Blvd Chevy Chase Md

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12-8-61

23c. NAME OF CEMETERY OR CREMATORY: SUBURBAN HOSPITAL

23d. LOCATION (City, town or county) (State): BETHESDA – MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: AMELIA C. CARTER (per F.B.) ADDRESS: ADMIN. – SUBURBAN HOSPITAL

25a. REC'D BY REGISTRAR DATE: DEC 12 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2074295XV2

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14123 **CERTIFICATE OF DEATH** 14092

Item 21 Film G303 12/21/61 iwk

1 4 M 74 I 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 34 Wheaton, Md.
d. STREET ADDRESS: 12706 Valleywood Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruth Middle: Andrea Last: Hall
4. DATE OF DEATH: Month: 12 Day: 2 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-25-08
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Kazey Illinois
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Hugh A Warman
14. MOTHER'S MAIDEN NAME: Wava Wood.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 163-14-3309
17. INFORMANT: Author R Hall. Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Confluent bronchopneumonia, lobular, bilateral, multilobar — INTERVAL BETWEEN ONSET AND DEATH: Several days
DUE TO (b):
DUE TO (c):
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardiovascular disease with coronary insufficiency.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 1960 to Nov 2 1961, that (I) (~~we~~) last saw the deceased alive on November 1 1961, and that death occured at 12:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: P. L. Tabb, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 11/2/61
22c. PHYSICIAN'S NAME (Type): S. L. TABB, M.D
22d. ADDRESS: 13,000 GEORGIA AVE S.L. Sp. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 12-2-61
23c. NAME OF CEMETERY OR CREMATORY: Valley Cemetery
23d. LOCATION (City, town or county) (State): Allegheny County, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14124 **CERTIFICATE OF DEATH** 14093

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 50 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 41 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Cumberland
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shippensburg
d. STREET ADDRESS: Star Route 2 75X-3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Walter; Middle: Stewart; Last: Hall

4. DATE OF DEATH: Month: December; Day: 11; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]
8. DATE OF BIRTH: November 1, 1899
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Hall
14. MOTHER'S MAIDEN NAME: Gertrude Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service): Unascertainable
16. SOCIAL SECURITY NO.:
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable clostridial septicemia — INTERVAL BETWEEN ONSET AND DEATH: ? 6-8 hours
DUE TO
(b) Gas gangrene of scrotum and perineum — ? 1 Day
DUE TO
(c) Chronic lymphocytic leukemia — 6 Months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204.10

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] **OR CONTRIBUTING** [ ] **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from October 31, 1961, to December 11 19 61 that (I) (we) last saw the deceased alive on December 11 19 61, and that death occured at 12:10 PM from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Henderson M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 12-11-61
22c. PHYSICIAN'S NAME (Type): Edward S. Henderson M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery
23d. LOCATION (City, town or county) (State): Shippensburg, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Crane

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14125

CERTIFICATE OF DEATH

Item 23b, Film G305 1/10/62 iwk

14094

1. PLACE OF DEATH
a. COUNTY: Montgomery — STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bethesda
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2015 Newton St., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First: Timothy — Middle: Allen — Last: Hamilton

4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 17 December 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: 8 — Min.: 7

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - - - - - - - - - -

10b. KIND OF BUSINESS OR INDUSTRY: - - - - - -

11. BIRTHPLACE (County & State, or foreign country): Montgomery, Maryland

12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: George Hamilton

14. MOTHER'S MAIDEN NAME: Evelyn Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: - - - - -

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PREMATURITY
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

776X

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Dec. 17, 1961, to Dec. 18, 1961, that I (we) last saw the deceased alive on Dec. 18, 1961, and that death occured at 3:10 AM from the causes and on the date stated above.

22a. SIGNATURE: Bernard H. Feldman M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: December 19, 1961

22c. PHYSICIAN'S NAME (Type): BERNARD H. FELDMAN LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/22/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: John T. Rhines — ADDRESS: JOHN T. RHINES & CO., 901 3rd St. SW, Washington D.C.

25a. REC'D BY REGISTRAR — DATE: DEC 26 '61

25b. REGISTRAR'S SIGNATURE: Carlton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

A. 2051316 X 12

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14126

CERTIFICATE OF DEATH

Reg. Dist. No. 14095

1. PLACE OF DEATH
a. COUNTY: Montgomery — Silver Spring — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 762 Silver Spring Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Springs
d. STREET ADDRESS: 762 Silver Springs Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: J — Last: Hayden

4. DATE OF DEATH: Month: December — Day: 4 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 19. 1874

9. AGE (In years last birthday): 87 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service

10b. KIND OF BUSINESS OR INDUSTRY: Government

11. BIRTHPLACE (State or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Elisha K Hayden

14. MOTHER'S MAIDEN NAME: Margaret Williams

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Daughter — Address: Mrs. Eva May Garrison — 762 Silver Springs Ave S. S. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 da
DUE TO
332X
(b) Cerebral Arteriosclerosis — years.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 19 61, to Dec, 19 61, that I last saw the deceased alive on Dec 3, 19 61, and that death occurred at 5:59 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert S. Poole M.D. — ADDRESS (Street, city or town, state): 4501 Conn. Ave N.W. — DATE SIGNED: 12/4/61

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/6/61

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cem

22d. LOCATION (City, town, or county) (State): Prince Georges County Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: W. K. Muntemann & Son — ADDRESS: Washington, D. C. 5732 Georgia Ave N. W.

24a. REC'D BY REGISTRAR DATE: DEC 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1 FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14127 14096

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day-9hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bethesda
d. STREET ADDRESS: 4616 Sleaford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pauline; Middle: E.; Last: Hellback

4. DATE OF DEATH: Month: Dec.; Day: 23; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 28, 1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Zorn
14. MOTHER'S MAIDEN NAME: Augusta Winkelman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: (Paula Fowler) daughter ----- Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH: Sudden

274X

DUE TO (b) Cardiorespiratory failure — 8 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Adrenal Insufficiency - Metastatic Carcinoma — unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 14 hours Status Postoperative - Nailing Rt Femur

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell on floor at home - Fracture Rt hip
20c. TIME OF INJURY: Hour 2:00 a.m. p.m. Month, Day, Year: 12-21 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town): Bethesda (County): Montg (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-23-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec.26,1961
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or country): Rockville (State): Md.

23. FUNERAL DIRECTOR: Raymond A. Ziska — ADDRESS: 8434 Georgia Ave., Silver Spring, Md.
Warner E. Pumphrey, Inc.
24a. REC'D BY REGISTRAR: DATE DEC 28 '61
24b. REGISTRAR'S SIGNATURE: Chalmers S. Thomas

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14128 — 14097

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg - RFD
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Monty.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg - RFD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edward — Middle: Osborne — Last: Henderson

4. DATE OF DEATH: Month: Dec — Day: 10 — Year: 1961

5. SEX: M -
6. COLOR OR RACE: W.
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 5 - 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm. Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Edward C. Henderson
14. MOTHER'S MAIDEN NAME: Susana E. Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):
(If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Leo Clagett, Address: Clarksburg Md RFD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): Arteriosclerotic Heart Disease — Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 20.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Feb. 19 57 to 12-10 1961, that (I) (we) last saw the deceased alive on Sept. 14 1961, and that death occured at 10 45 a.m., from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 12-11-61
22c. PHYSICIAN'S NAME (Type): JACK SCHUMACHER
22d. ADDRESS: GAITHERSBURG MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's
23d. LOCATION (City, town or county) (State): Rockville, Md

24 FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton
ADDRESS: Barnesville, Md
25a. REC'D BY REGISTRAR DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14129

CERTIFICATE OF DEATH

14098

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rockville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 123 S. Adams Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 1 123 S. Adams Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LAVINIA Middle: DAWSON Last: HENDERSON

4. DATE OF DEATH: Month: Dec. Day: 28, Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 1, 1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months: 10 Days: 27 IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Rockville, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Thomas Dawson
14. MOTHER'S MAIDEN NAME: Mary Alice Peter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 215-38-3122B
17. INFORMANT: Son Joseph Henderson Address: Same as #2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	10 min
DUE TO		
(b)	coronary insufficiency	5 years
DUE TO		
(c)	arteriosclerotic cardiovascular disease	5 years

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from Feb. 25, 1957 to Dec. 28, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec. 23, 1961, and that death occured at 7:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Stephen C. Cromwell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 28, 1961
22c. PHYSICIAN'S NAME (Type): STEPHEN C. CROMWELL, JR.
22d. ADDRESS: 615 W. Montgomery Ave, Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-30-61
23c. NAME OF CEMETERY OR CREMATORY: Rockville Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: [illegible]

VR A15 (4)
1SM 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14130 **CERTIFICATE OF DEATH** 14099

1 /12

M

75

I

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 53 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash. San & Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md - Montgomery
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Silver Spring
d. STREET ADDRESS: 503 Stirling Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stanley — Middle: S. — Last: Henderson

4. DATE OF DEATH: Month: 12 — Day: 11 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-23-02

9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist

10b. KIND OF BUSINESS OR INDUSTRY: Govt Printing Office

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Franklin Edward Henderson

14. MOTHER'S MAIDEN NAME: Jenny Fones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Margaret S. Henderson — Address: 503 Stirling Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19 55, to Dec 11, 1961, that (I) (~~we~~) last saw the deceased alive on Dec 11 1961, and that death occured at 8 45 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Raymond Bradshaw M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/11/61

22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw

22d. ADDRESS: 345 University Blvd, West, Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/15/61

23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemtery

23d. LOCATION (City, town or county) (State): Montgomery Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond G. Zaska — ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.

25a. REC'D BY REGISTRAR DATE: DEC 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14131 14100

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Warren
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Front Royal
d. STREET ADDRESS: 13 Cherrywood Apartments
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

50

83x·3

3. NAME OF DECEASED (Type or print): First: Helen — Middle: Agatha — Last: Henry

4. DATE OF DEATH: Month: December — Day: 5 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 29, 1921

9. AGE (In years last birthday): 40 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles F. Carbaugh

14. MOTHER'S MAIDEN NAME: Virginia Lemley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 227-22-0908

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Probable septicemia — INTERVAL BETWEEN ONSET AND DEATH: 14 days

DUE TO (b): Acute myelocytic leukemia with hepatomegaly (1800 grams) and splenomegaly (325 grams) — 3 months

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

204.2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (☒ (this hospital) attended the deceased from Nov. 8, 1961 to Dec. 5, 1961, that (☒ (we) last saw the deceased alive on Dec. 5 1961, and that death occured at 10:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: J. David Heywood M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: December 6, 1961

22c. PHYSICIAN'S NAME (Type): J. David Heywood, M.D.

22d. ADDRESS: The Clinical Center, the National Institutes of Health, Bethesda 14, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 12-8-61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Prospect Hill Cem.

23d. LOCATION (City, town or county) (State): Front Royal, Virginia.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland — Bethesda Md

25a. REC'D BY REGISTRAR DATE: DEC 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

1

M

94

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14132

CERTIFICATE OF DEATH

Reg. Dist. No. 11101

1. PLACE OF DEATH a. COUNTY Montgomery County — Ursuline Academy, Bethesda — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b: 13 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ursuline Academy Forest Lane

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X

d. STREET ADDRESS: 9900 Forest Lane

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (Mother Agnes) First: Sarah Middle: Last: Herkness

4. DATE OF DEATH Month: December Day: 28 Year: 1961

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 2 1879

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mother Agnes of the Ursuline Nuns

10b. KIND OF BUSINESS OR INDUSTRY: Philadelphia Pa.

11. BIRTHPLACE (State or foreign country): Philadelphia Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Herkness

14. MOTHER'S MAIDEN NAME: Sarah Strain

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Records of Ursuline Academy Bethesda 14 Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRCULATORY COLLAPSE — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b) AURICULAR FIBRILLATION — 1 MONTH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE — 10+ YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): PYELONEPHRITIS & CYSTITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from MARCH 1954 to 12/28 1961 that I last saw the deceased alive on 12/26 1961, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles J Savarese M.D. — ADDRESS (Street, city or town, state): 4890 Battery Lane Bethesda — DATE SIGNED: 12/28/61

PHYSICIAN'S NAME (Type): Charles J. Savarese Jr. M.D. 4890 Battery Lane Bethesda 14 Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 12/30/1961

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d. LOCATION (City, town, or county) (State): Dash D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: P Haffee — ADDRESS: 475-H-ST. N W DC

24a. REC'D BY REGISTRAR DATE: JAN 5 '62

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete[illegible] filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. [illegible] 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14133

CERTIFICATE OF DEATH

14102

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital or institution, give street address): Kensington Gardens Sanitarium 3000 McComas Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Bethesda
d. STREET ADDRESS: 7816 Stratford Pl.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Camille — Middle: — Last: Hindmarsh
4. DATE OF DEATH: Month: December — Day: 3 — Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 18, 1872
9. AGE (In years lost birthday): 89 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Edmond H. Becker
14. MOTHER'S MAIDEN NAME: Emma Brica
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Edmund Becker-Brother-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiovascular Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days
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DUE TO
(b) Generalized arteriosclerosis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Fracture Rt. Pubic Bone - one week.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell Nov. 25, 1961 at Nursing Home
20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1951 19__, to Dec 3 1961, that (I) (we) last saw the deceased alive on Dec. 2 1961, and that death occurred at 12:40 PM, from the causes and on the date stated above.

22a. SIGNATURE: Thomas E Curtin M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 3, 1961
22c. PHYSICIAN'S NAME (Type): X THOMAS E. CURTIN
22d. ADDRESS: 4600 Connecticut Ave N.W. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/5/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

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Coroner Notified & Approved.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14134 14103

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sant Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1656.2
d. STREET ADDRESS: 1424 University Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jacob; Middle: (NMN); Last: Hoffman

4. DATE OF DEATH: Month: Dec; Day: 1; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-27-95

9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Auto Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Hoffman

14. MOTHER'S MAIDEN NAME: Anna Kaplan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Army W.W.I.

16. SOCIAL SECURITY NO.: 569-01-3151

17. INFORMANT: Hospital Records. — Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS.
DUE TO (b): ANGINA PECTORIS — 3-4 YRS
DUE TO (c): GENERALIZED ARTERIOSCLEROSIS — 5-6 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): DIABETES MELLITUS & CHRONIC BRONCHITIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/29, 1961, to 12/1, 1961, that (I) (we) last saw the deceased alive on 11/30 1961, and that death occured at 7:40 AM from the causes and on the date stated above.

22a. SIGNATURE: Harold Sterling M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HAROLD STERLING M.D.

22d. ADDRESS: 1352 UNIVERSITY BLVD HYATTSVILLE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-4-61

23c. NAME OF CEMETERY OR CREMATORY: MT. LEBANON CEMETERY

23d. LOCATION (City, town or county) (State): HYATTSVILLE MD

24. FUNERAL DIRECTOR'S SIGNATURE: Gelberg Funeral Home — **ADDRESS**: 4217 Georgia Ave N.W. D.C.

25a. REC'D BY REGISTRAR DATE: DEC 5 '61

25b. REGISTRAR'S SIGNATURE: Anthony S. Krauss

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14135 14104

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Georgia
b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Atlanta 49X-3
d. STREET ADDRESS: 1599 Sandtown Road South West
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dorothy; Middle: Ann; Last: Holcombe

4. DATE OF DEATH: Month: December; Day: 23; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: November 13, 1955

9. AGE (In years last birthday): 6 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leonard Eugene Holcombe

14. MOTHER'S MAIDEN NAME: Beverly Lee McKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Year
DUE TO (b) Cystic Fibrosis — 6 Years
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from December 14, 19 61 to December 23, 19 61, that (I) (we) last saw the deceased alive on December 23, 19 61, and that death occured at 12:08 PM from the causes and on the date stated above.

22a. SIGNATURE: William O. Jones M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-23-61

22c. PHYSICIAN'S NAME (Type): William O. Jones M.D.

22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 12/23/61

23c. NAME OF CEMETERY OR CREMATORY: --

23d. LOCATION (City, town or county) (State): Atlanta, Georgia

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.

ADDRESS: 2901 14th St., N.W. Washington, D.C.

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14136 **CERTIFICATE OF DEATH** 14105

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 2hrs 25 min
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 CROPLEY (mail) Box Bethesda
d. STREET ADDRESS: 10701 McARTHUR BLVD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MILDRED Middle: E Last: HOLT

4. DATE OF DEATH: Month: 12. Day: 5 Year: 1961

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 11 · 11 · 09
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (County & State, or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Husband, Address: Same Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): INTRACerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1-2 days
331X DUE TO (b): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 5, 1961 to Dec 5, 1961 that (I) (we) last saw the deceased alive on Dec 5 1961 and that death occured at 2354 p.M. from the causes and on the date stated above.

22a. SIGNATURE: John J. Curry M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/5/61
22c. PHYSICIAN'S NAME (Type): John J. Curry
22d. ADDRESS: 10620 Georgia Ave S.S. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/8/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2 Dr Brent notified

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14137 **CERTIFICATE OF DEATH** 14106

Item 23b Film 6304 12/29/61 mh

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X.3
d. STREET ADDRESS: 1321 Shepard Street NW
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Almer; Middle: Lee; Last: Hopkins
4. DATE OF DEATH: Month: December; Day: 15; Year: 1961
5. SEX: Male
6. COLOR OR RACE: Negroid
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: February 2, 1910
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Serviceman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Elijah Hopkins
14. MOTHER'S MAIDEN NAME: Margaret Osborn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Reticulum cell sarcoma, massive, retroperitoneum
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov. 25, 1961, to Dec. 15, 1961 that (I) (we) last saw the deceased alive on Dec. 15, 1961, and that death occured at 3:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Adam T. Thorp Jr. M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: December 15, 1961
22c. PHYSICIAN'S NAME (Type): ADAM T. THORP JR. LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 20, 1961
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Crouches Funeral Home
ADDRESS: 51 K Street, N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14138 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14107

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring 22
d. STREET ADDRESS: 404 E. Melbourne Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hosea — Middle: Anson — Last: Hughes
4. DATE OF DEATH: Month: December — Day: 3 — Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 12, 1891
9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Printer
10b. KIND OF BUSINESS OR INDUSTRY: Trade Unionist
11. BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Hosea Hughes
14. MOTHER'S MAIDEN NAME: Nellie Barton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 577-03-3175
17. INFORMANT: wife — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 12-3-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/5/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or country) (State): Prince Georges, Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska — ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
WARNER E. PUMPHREY, INC.
24a. REC'D BY REGISTRAR: DATE DEC 5 '61
24b. REGISTRAR'S SIGNATURE: Clarence S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14139

CERTIFICATE OF DEATH

14108

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 52 Chevy Chase
d. STREET ADDRESS: 3208 - Rolling Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Ida Middle: M. Last: Hultgren
4. DATE OF DEATH: Month: Dec. Day: 19 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2-19-84.
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Helsel
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO. (If yes give war or dates of service): No ~~577-16-4859D~~
17. INFORMANT: Gladys M. Roeser Address: Same As Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 3 days
600.0
DUE TO (b): Septicemia — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis. Diabetes Mellitus. Bronchopneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 8, 1961, to Dec 15, 1961, that (I) (we) last saw the deceased alive on Dec 19 1961, and that death occured at 8 P.M., from the causes and on the date stated above.

22a. SIGNATURE: J. X. Reedy M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-19-61
22c. PHYSICIAN'S NAME (Type): J. R. Reedy
22d. ADDRESS: 3701 Veland St Ch Ch Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 22 '61
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14140 14109

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8909 Ridge Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kathryn; Middle: L.; Last: Hutchison

4. DATE OF DEATH: Month: Dec.; Day: 26; Year: 19 61

5. SEX: Fenale
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/10/86
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Young
14. MOTHER'S MAIDEN NAME: Elizabeth Weber

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Janice H. Ale (daughter) Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days
DUE TO (b): Generalized Arteriosclerosis — 4 yrs
DUE TO (c):
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/27, 1964 to Dec 26, 1961, that (I) (we) last saw the deceased alive on Dec 26 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Leo I Donovan M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/61
22c. PHYSICIAN'S NAME (Type): LEO I DONOVAN MD
22d. ADDRESS: 8218 Wisc. Ave

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/29/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cem.
23d. LOCATION (City, town or county) (State): Rockville Md

24. FUNERAL DIRECTOR'S SIGNATURE: Cherry Chase Funeral Home
ADDRESS: 5101 Wisc. Ave. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 29 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14141 14110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 18 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital Bethesda

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Washington — b. COUNTY: DC
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District of Columbia 47X·3
d. STREET ADDRESS: 908 Shepard St. N.W.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rose — Middle: (N) — Last: JARSON
4. DATE OF DEATH: Month: December — Day: 9 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1 Feb 1875
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? Russia
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: (Son) Maurice Jarson — Address: 706 Navy Blvd Pensacola, Fla.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Encephalopathy
DUE TO (b) arteriosclerosis and hypertension undetermined
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 444X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 21 Nov 1961 to 9 Dec 1961, that (I) (we) last saw the deceased alive on 9 Dec 1961 and that death occured at 1:15 PM from the causes and on the date stated above.

22a. SIGNATURE: Paul G. Linaweaver
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 9 Dec 1961
22c. PHYSICIAN'S NAME (Type): LCDR Paul G. Linaweaver MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 10 Dec 1961
23c. NAME OF CEMETERY OR CREMATORY: EZRAS ISRAEL
23d. LOCATION (City, town or county) (State): CAPITAL HEIGHTS, MARYLAND
24. FUNERAL DIRECTOR'S SIGNATURE: GOLDBERG — ADDRESS: 4217 9th St. NW WASH, DC.
25a. REC'D BY REGISTRAR — DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14142 **CERTIFICATE OF DEATH** 14111

M

75

I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: D.C.
b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 20, D.C. 47X3
d. STREET ADDRESS: 800 Barnaby Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jeffries; Middle: Baby; Last: Boy
4. DATE OF DEATH: Month 12; Day 11; Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/9/61
9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR: Months; Days 1; IF UNDER 24 HRS.: Hours 16; Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no
10b. KIND OF BUSINESS OR INDUSTRY: no
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? America
13. FATHER'S NAME: Larry Nicholas Ladrido
14. MOTHER'S MAIDEN NAME: Marsha Elaine Jeffries
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: mother — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis
DUE TO (b):
DUE TO (c): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-9, 1961, to 12-11, 1961, that (I) (we) last saw the deceased alive on 12-11 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Robert B. Irey M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-14-61
22c. PHYSICIAN'S NAME (Type): Robert Irey, M. D.
22d. ADDRESS: 7105 Riggs Rd., Lewisdale, Maryland

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23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-12-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.
ADDRESS: Washington San. & Hospital
2Se. REC'D BY REGISTRAR: DEC 18 '61
2Sb. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2075151XVI

Item 18 Film 307 2-20-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14143 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14112

1 FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk
c. LENGTH OF STAY IN 1b: 2 wks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 909 Maplewood Cwz

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Takoma Park
d. STREET ADDRESS: 909 Maplewood Cwz
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Ellis — Last: Johnson

4. DATE OF DEATH: Month: Dec — Day: 31 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-2-13

9. AGE (In years last birthday): 48 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: auto

11. BIRTHPLACE (State or foreign country): Va. Fredericksburg - S. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George E. Johnson

14. MOTHER'S MAIDEN NAME: Frances E. George

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 579-05-9948

17. INFORMANT: Ella Flurhartz — Address: Friend Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PEHHNIG Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: ACUTE
581.1

DUE TO (b) Fatty degeneration of liver - Edema of lungs — ?

DUE TO (c) Chronic alcoholism

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Found dead at foot of basement stairs, at home

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Fell down basement stairs at home

20c. TIME OF INJURY Hour a.m. 8:30 — Month, Day, Year 12-31 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Takoma Pk — (County): Monty — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D.

EXAMINER'S NAME (Type) FRANK J. BROSCHART — Address (Street, city, town, or county)

DATE SIGNED 12-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: Jan. 3/62

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or country) (State): Colma Manor, Md.

23. FUNERAL DIRECTOR: Malley's Funeral Home, Inc. — ADDRESS: Mt. Rainier Maryland

24a. REC'D BY REGISTRAR — DATE JAN 4 '62

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14144

CERTIFICATE OF DEATH

14113

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 33 Rockville
d. STREET ADDRESS: 12622 Grandmar St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Jones

4. DATE OF DEATH: Month: Dec — Day: 1 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: Dec 1, 1961
9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours 1 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Herbert Jones
14. MOTHER'S MAIDEN NAME: Vivian Burgess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Father — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio-respiratory failure
DUE TO (b): Anencephaly
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

>50X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1, 1961, to Dec 1, 1961, that (I) (we) last saw the deceased alive on Dec 1, 1961, and that death occured at 7:35 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph O'Neil M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/1/61
22c. PHYSICIAN'S NAME (Type): Joseph O'Neil
22d. ADDRESS: 809 Viers Mill Rd. Rockville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
23b. DATE THEREOF: 12-2-61
23c. NAME OF CEMETERY OR CREMATORY: SUBURBAN HOSPITAL
23d. LOCATION (City, town or county) (State): BETHESDA, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Amelia C. Carter (per F.B.) — ADDRESS: Suburban Hosp. Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Clifford L. Pruitt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14145 **CERTIFICATE OF DEATH** 14114

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D. C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47 X 3
d. STREET ADDRESS: 926 Massachusetts Ave. NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olia; Middle: Mae; Last: Jones

4. DATE OF DEATH: Month: December; Day: 12; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 16, 1881

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Cooper

14. MOTHER'S MAIDEN NAME: Ellen Cushcar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wars or dates of service): - - - -

16. SOCIAL SECURITY NO.: - - - -

17. INFORMANT Address: HUSBAND: Calvin A. Jones, Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
420.0
DUE TO (b): Arteriosclerotic Heart Disease — months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec. 12, 1961, to Dec. 12, 1961, that (I) (we) last saw the deceased alive on Dec. 12 1961, and that death occured at 11:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Paul G. Linaweaver LCDR MC USN M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: December 13, 1961

22c. PHYSICIAN'S NAME (Type): PAUL G. LINAWEAVER LCDR MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-16-61

23c. NAME OF CEMETERY OR CREMATORY: Columbia Gardens

23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home

ADDRESS: Lee Funeral Home, 4th & Massachusetts Ave, NE, WDC

25a. REC'D BY REGISTRAR DATE: DEC 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14146 **CERTIFICATE OF DEATH** 14115

1 M

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): MONTGOMERY GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 53 CHEVY CHASE
d. STREET ADDRESS: 19 GRAFTON STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

73

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
PAUL	NMN	Judson	12	4	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE		4/6/61	- yrs.	8			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT JUDSON
14. MOTHER'S MAIDEN NAME: MARCIA BARTLETT

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: HOSPITAL RECORDS — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, BILATERAL.
DUE TO
(b) TRACHEOBRONCHITIS, SEVERE.
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

50/X

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
MONGOLISM, CONGENITAL.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER):
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): -

20c. TIME OF INJURY Hour a.m. p.m. - Month, Day, Year - 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from JUNE 19 1+ to DEC. 4, 19 61, that (I) (we) last saw the deceased alive on DEC. 3 19 61, and that death occured at 5:40A M, from the causes and on the date stated above.

22a. SIGNATURE: Chwhitaker, M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/4/61
22c. PHYSICIAN'S NAME (Type): CHARLES S. WHITAKER, M.D.
22d. ADDRESS: CLARKSVILLE, MARYLAND

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Bremation
23b. DATE THEREOF: 12-5-61
23c. NAME OF CEMETERY OR CREMATORY: Loudin Park
23d. LOCATION (City, town or county) (State): Baltimore, Md

24. FUNERAL DIRECTOR'S SIGNATURE: F.C. Higenbotham
ADDRESS: Laurel City Md
25a. REC'D BY REGISTRAR DATE DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

-9 V V V V V V X V V

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14147 **CERTIFICATE OF DEATH** 14116

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Anhorige
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

55 X 3

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: Bedinger; Last: KIEREN

4. DATE OF DEATH: Month: December; Day: 31; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: July 8, 1897

9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel L. Bedinger

14. MOTHER'S MAIDEN NAME: Eleanor G. Campbell — U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of endometrium — INTERVAL BETWEEN ONSET AND DEATH: 5 yr.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

172X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from 6 December, 1961 to 31 December 1961, that XX (we) last saw the deceased alive on 31 December 1961, and that death occured at 2:45P M, from the causes and on the date stated above.

22a. SIGNATURE: Robert H. Perkins LT MC USN M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. XX

22b. DATE SIGNED: DECEMBER 31, 1961

22c. PHYSICIAN'S NAME: ROBERT H. PERKINS LT MC USN

22d. ADDRESS: U. S. Naval Hospital Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 1-5-62

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert H. Pumphrey — ADDRESS: Bethesda, Md.
Robert H. Pumphrey Funeral Home, 7557 Wisconsin Ave.

25a. REC'D BY REGISTRAR DATE: JAN 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

Kentucky

Ashbridge

U.S. Naval Hospital

Josephine Boninger CLERK December 31 63

Jamie Dunnsian X July 6,1927 64

Honeville Virginia U.S.N.A.

Ronald T. Bedinger Hanoor G. Campbell

No Hospital Records

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14148 **CERTIFICATE OF DEATH** 14117

Items 11 & 12 Film G303 12/26/61 mh

1. **PLACE OF DEATH**
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. NAVAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 BETHESDA
d. STREET ADDRESS: 7913 DEEP WELL DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First EARLE Middle HILL Last KINCAID

4. **DATE OF DEATH**: Month DECEMBER Day 13 Year 1961

5. SEX: Male
6. COLOR OR RACE: Cau
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-19-94
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES A. KINCAID
14. MOTHER'S MAIDEN NAME: EMMA GILBERT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. **INFORMANT** Address: Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		Interval between onset and death
IMMEDIATE CAUSE (a)	cerebral hemorrhage	6 hours
DUE TO (b)	arteriosclerosis and hypertension	16 years
DUE TO (c)		

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from 13 DEC, 1961 to 13 DEC, 1961, that (X) (we) last saw the deceased alive on 13 DEC 1961, and that death occured at 11:40 PM from the causes and on the date stated above.

22a. SIGNATURE: David Goldblatt M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 14 Dec. 61
22c. PHYSICIAN'S NAME (Type): DAVID GOLDBLATT LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-18-61
23c. NAME OF CEMETERY OR CREMATORY: Arlington National
23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler's Funeral Home, Washington, D.C.
ADDRESS:
25a. REC'D BY REGISTRAR DATE DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14149

CERTIFICATE OF DEATH

14118

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1 mth
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Kensington
d. STREET ADDRESS: 10039 Frederick Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BERNADETTE Middle: OLIVIA Last: KINGSBURY

4. DATE OF DEATH: Month: Dec. Day: 12. Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 16, 1878

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (County & State, or foreign country): Montgomery County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Thomas Kingsbury

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: J. Manning Kingsbury
Address: (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b) Chronic pulmonary fibrosis — 5 days
DUE TO (c)

52 S X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 19 57 to Dec. 12, 1961, that (I) (we) last saw the deceased alive on Dec 11 1961, and that death occured at 10:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: J. E. Fitzgerald M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/12/61

22c. PHYSICIAN'S NAME (Type): J. E. FITZGERALD

22d. ADDRESS: 3750 - Reservoir Rd NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 15, 1961

23c. NAME OF CEMETERY OR CREMATORY: St Mary's Cemetery

23d. LOCATION (City, town or county): Barnesville (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Gatto ADDRESS: 254 Carroll St. NW Washington DC

25a. REC'D BY REGISTRAR DATE: DEC 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14150 **CERTIFICATE OF DEATH** 14119

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 36 KENSINGTON
d. STREET ADDRESS: 2902 MC COMAS AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CATHERINE Middle L Last KOUNS
4. DATE OF DEATH: Month Dec. Day 14 Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 2/16/95
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Retired~~ HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Dillon
14. MOTHER'S MAIDEN NAME: Mary Lee Stone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Daughter Mrs. Mary Botts — Address: Same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) CARDIAC ARREST

540.0

DUE TO (b) MASSIVE ATELECTASIS — 1hr ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) RESPIRATORY INSUFFICIENCY

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): BLEEDING GASTRIC ULCER - SUBTOTAL GASTRECTOMY FOR,

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from DEC 6, 1961, to DEC 14, 1961, that (I) (~~we~~) last saw the deceased alive on DEC 14 1961, and that death occured at 1:55 AM, from the causes and on the date stated above.

22a. SIGNATURE: John P. Haberlin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-14-61
22c. PHYSICIAN'S NAME (Type): HABERLIN
22d. ADDRESS: 1015 SPRING ST ~~SILVER~~ SPRING, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/16/61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Calvin S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14151 **CERTIFICATE OF DEATH** 14120

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 37 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Washington
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Of Columbia
d. STREET ADDRESS: 3236 Prospect Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Carolyn — Last: Latimer
4. DATE OF DEATH: Month: December — Day: 7, — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: May 25, 1929
9. AGE (In years last birthday): 32 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Legislative Assistant
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government
11. BIRTHPLACE (County & State, or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Carl Ernest Ames
14. MOTHER'S MAIDEN NAME: Dorothy Banfield
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give year or dates of service):
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 min.

DUE TO (b) Pulmonary Embolus — 5 min

DUE TO (c) Congenital or Rheumatic Heart Disease - Aortic Stenosis — 31 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from October 31, 19 61 to December 7, 19 61 that I (we) last saw the deceased alive on December 7, 19 61, and that death occured at 3:50 PM from the causes and on the date stated above.

22a. SIGNATURE: Kenneth L. Melmon M.D.
22b. DATE SIGNED: December 8, 1961
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Kenneth L. Melmon, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 8, 1961
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town or county) (State): Los [redacted] Angeles, Calif.

24. FUNERAL DIRECTOR'S SIGNATURE: W W Tattowell, ADDRESS: 3603 14th St NW Wash DC
25a. REC'D BY REGISTRAR: DEC 11 61 — DATE
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [redacted]th. Page 4 may be retained by the hospital or attending physician.
[redacted] FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [redacted]pletely filled in by the funeral [redacted]irector, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[redacted] VR A15 (4) 15M 9/60

Burial Dec. 8, 1961 Los Angeles, Calif.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14152 **CERTIFICATE OF DEATH** 14121

M 50 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Campbell
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lynchburg
d. STREET ADDRESS: Route #1, Lemon Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

83 X 3

3. NAME OF DECEASED (Type or print): First KENNETH Middle EUGENE Last LAYNE
4. DATE OF DEATH: Month December Day 12 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12 June 1943
9. AGE (In years last birthday): 18 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Medical Center
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Layne
14. MOTHER'S MAIDEN NAME: Elsie Dodson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 227-54-5827
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intracranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
204.3
DUE TO
(b) Urate Nephropathy — 24 hrs.
DUE TO
(c) Acute Lymphocyte Leukemia — 10 mos.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from November 27, 1961, to December 12 1961, that I (we) last saw the deceased alive on December 12 19 61, and that death occured at 3:10 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Henderson M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/12/61
22c. PHYSICIAN'S NAME (Type): EDWARD S. HENDERSON, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery
23d. LOCATION (City, town or county) (State): Lynchburg, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14153

CERTIFICATE OF DEATH

Reg. Dist. No. 1122

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Potomac

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ropine Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville

d. STREET ADDRESS: 715 Marshall Avenue

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LOUIS — Middle: (NMI) — Last: LEIBROCK

4. DATE OF DEATH: Month: December — Day: 15, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 7, 1880

9. AGE (In years lost birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Machenist

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 272-03-2602

INFORMANT: Mrs ~~xxxxxx~~ Ann L. Welsh - Item # 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) UREMIA - (RENAL AZOTEMIA) — INTERVAL BETWEEN ONSET AND DEATH: 14 DAYS
593X
DUE TO
(b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) CHRONIC RENAL FAILURE — 20 YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): OLD FRACTURE RIGHT HIP - PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour: a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from SEPT 27, 1961, to DEC. 16, 1961, that I last saw the deceased alive on December 15 1961, and that death occurred at 9:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gordon S. Rosenberger M.D. — ADDRESS (Street, city or town, state): 310 W. Montgomery Ave, Rockville, Maryland — DATE SIGNED: Dec 15, 1961

PHYSICIAN'S NAME (Type): Gordon S. Rosenberger

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 12/15/61

22c. NAME OF CEMETERY OR CREMATORY: The West Part Cemetery

22d. LOCATION (City, town, or county) (State): Cleveland, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home — ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 18 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14154 Item 8 Film G303 12/21/61 iwk

CERTIFICATE OF DEATH

14123

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Olney
d. STREET ADDRESS:
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wade — Middle: Hamilton — Last: Leizear
4. DATE OF DEATH: Month: 12 — Day: 11 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/3/79 1880
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Montg. Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Samuel Leizear
14. MOTHER'S MAIDEN NAME: Annie Pagett
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 217-14-6652
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARTION — INTERVAL BETWEEN ONSET AND DEATH: 5 days
420.1
DUE TO (b): CORONARY ATERIOSCLEROSIS — 10 yr
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1961 to Dec, 1961, that (I) (we) last saw the deceased alive on Dec 10 1961, and that death occured at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: A. D. Bonifant M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A.D.Bonifant
22d. ADDRESS: Sandy Spring, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec.14,1961
23c. NAME OF CEMETERY OR CREMATORY: St. John's
23d. LOCATION (City, town or county) (State): Olney, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
25e. REC'D BY REGISTRAR DATE: DEC 14 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

Acute Myocardial Infarction
Coronary Arteriosclerosis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14155

CERTIFICATE OF DEATH

14124

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1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 45days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg — Route 1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anna — Middle: Magrel — Last: Lifka

4. DATE OF DEATH: Month: December — Day: 13, — Year: 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 29, 1895
9. AGE (In years last birthday): 66 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home-making
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? ~~unknown~~ USA

13. FATHER'S NAME: Karl Magrel
14. MOTHER'S MAIDEN NAME: Elizabeth Woiafka

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pseudomucinous Cyst
175.0
DUE TO (b) Adenocarcinoma, Ovary Left, Metastatic.
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 7 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Apr., 1961 to 12-13, 1961, that (I) (~~we~~) last saw the deceased alive on 12-13 1961, and that death occured at 6:50 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacher M.D.
22b. DATE SIGNED: 12-15-61
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): JACK SCHUMACHER, M.D.
22d. ADDRESS: GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 16 1961
23c. NAME OF CEMETERY OR CREMATORY: Gate Of Heaven
23d. LOCATION (City, town or county) (State): Silver Spring Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 (M)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14156

CERTIFICATE OF DEATH

14125

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda - 9200 Wisc Ave

c. LENGTH OF STAY IN 1b: 18 months

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Washington DC — b. COUNTY: ✓

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47x3

d. STREET ADDRESS: 825 New Hampshire Ave NW

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

3. NAME OF DECEASED (Type or print): First: HANNA — Middle: ANDERSON — Last: LINDSTROM

4. DATE OF DEATH: Month: 12 — Day: 30 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2/15/1887

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days. IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (State or foreign country): SWEDEN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ANDREA ANDERSON

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: HAROLD LINDSTROM (son) Address: 825 New Hampshire Ave NW

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARDIAC ARRHYTHMIA — INTERVAL BETWEEN ONSET AND DEATH: minutes

420.1

DUE TO (b): CONGESTIVE HEART FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): CORONARY ARTERY DISEASE

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

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20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from May 1960 to Dec. 1961, that (I) (~~saw~~) lost saw the deceased alive on 12/30 1961, and that death occurred at 10:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ROBERT F. DYER, M.D.

22d. ADDRESS: 915 19th ST. N.W. Wash, D.C.

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23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 1/6/62

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMO. PARK

23d. LOCATION (City, town, or county) (State): MINNEAPOLIS, MINN.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: 3072 M St NW Wash DC

25a. REC'D BY REGISTRAR: DATE JAN 4 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14157 Items 13 & 14 Film G304 1/2/62 iwk 14126

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Wheaton
d. STREET ADDRESS: 12 111 Valley wood Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Caroline Middle: Last: Locken

4. DATE OF DEATH: Month: Dec. Day: 25 Year: 1961

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: May 14, 1910
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months: 7 Days: 11
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper
10b. KIND OF BUSINESS OR INDUSTRY: private
11. BIRTHPLACE (County & State, or foreign country): South Dakota
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Suburban Hosp. Records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day
570.5
DUE TO (b) leakage, anastomotic site — 1 Day
DUE TO (c) Obstruction small intestine, Status post operative — 6 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
Bilateral Atelectasis with pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12/18, 1961, to 12/25, 1961, that (I) (~~we~~) last saw the deceased alive on 12/25 1961, and that death occured at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Frederick Y. Donn M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/61
22c. PHYSICIAN'S NAME (Type): Frederick Y. Donn
22d. ADDRESS: 1835 I St., N.W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 12-27-61
23c. NAME OF CEMETERY OR CREMATORY: St. Peter & Paul Cem.
23d. LOCATION (City, town or county) (State): Dimock, South Dakota.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE: DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Clifford S. Krauss

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14158 Item 1 Film G304 1/4/62 iwk 14127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 49 I

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hosp. (died enroute to Hosp.) 5609 Johnson Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Bethesda
d. STREET ADDRESS: 5609 Johnson Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: H — Last: Logan
4. DATE OF DEATH: Month: December — Day: 28 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/11/1878
9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months 4 Days 17 — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (County & State, or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Luke Allen Howland
14. MOTHER'S MAIDEN NAME: (Unknown) Perkins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. James Davis-Daughter-same 2d — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary Edema
420.0
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/11/59, 19 to 12/28/61, 19, that (I) (we) last saw the deceased alive on 12/28/1961, and that death occured at 1 AM, from the causes and on the date stated above.

22a. SIGNATURE: W. T. Joyce M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/28/61
22c. PHYSICIAN'S NAME (Type): W. T. Joyce
22d. ADDRESS: 8106 Maple Ridge Rd., Bethesda Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 1/2/62
23c. NAME OF CEMETERY OR CREMATORY: Howland Cemetery
23d. LOCATION (City, town or county) (State): Quincy, Kentucky

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14159 **CERTIFICATE OF DEATH** 14128

M

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 3½ Mo.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 30 Silver Spring
d. STREET ADDRESS: 9620 Bruce Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

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3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Maude	Vernon	Long	12	1	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months, Days	IF UNDER 24 HRS.: Hours, Min.
female	white		12/2/1880	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pt.Republic, Va.	U.S.A.

13. FATHER'S NAME: Franklin Hudlow
14. MOTHER'S MAIDEN NAME: Lucy Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Nursing Home Records- Address: Wheaton, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
170 X
DUE TO (b) Carcinoma R. Breast-metastatic — 6yrs.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): arteriosclerotic heart disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 18 NOV, 1961 to 1 DEC, 1961 that (I) (we) last saw the deceased alive on 27 NOV 1961, and that death occured at 12:25 M. from the causes and on the date stated above.

22a. SIGNATURE: Ira N. Tublin M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Ira N. Tublin
22d. ADDRESS: 25 E. Wayne Ave. Silver Spring Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 12/4/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
23d. LOCATION (City, town or county) (State): Suitland, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR DATE DEC 4 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14160

CERTIFICATE OF DEATH

14129

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural- Lewisdale
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RFD # 1, Monrovia

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural- Lewisdale
d. STREET ADDRESS: RFD # 1, Monrovia
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Tywana; Middle: Renae; Last: Lyles

4. DATE OF DEATH: Month: Dec.; Day: 1; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March ~~24~~ 9, 1961

9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months: 8; Days: 7; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Lyles

14. MOTHER'S MAIDEN NAME: Margaret Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): -
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: --

17. INFORMANT: George Lyles, Item 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchial asthma — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Acute tracheobronchitis — 2 days.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
501X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/29, 1961, to 12/1, 1961, that (I) ~~(we)~~ last saw the deceased alive on 12/1, 1961, and that death occured at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James P. Kerr M.D. — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/1/61
22c. PHYSICIAN'S NAME (Type): James P. Kerr
22d. ADDRESS: Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/3/61
23c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
23d. LOCATION (City, town or county) (State): Purdum, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Olin L. Molesworth
ADDRESS: Damascus, Md.
25a. REC'D BY REGISTRAR DATE: DEC 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

2069304-XV6

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14161

CERTIFICATE OF DEATH

Reg. Dist. No. 14130

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: —
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington - DC. 47x-3
d. STREET ADDRESS: 3825 Legation St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Martha; Middle: C.; Last: Macatee

4. DATE OF DEATH: Month: 12; Day: 22; Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 28 - 1878

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Christ. Science Practitioner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mobile Bay. Alabama

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Robinson B. Murphy

14. MOTHER'S MAIDEN NAME: Lina Doron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO (b): Hypertensive C-V Disease — 1 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-22-, 1961, to 12-22, 1961, that I last saw the deceased alive on 12-19, 1961, and that death occurred at 1 A. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: C. H. Linton M.D.
ADDRESS (Street, city or town, state): Sandy Spring
DATE SIGNED: 12/22/61
PHYSICIAN'S NAME (Type): C. H. Linton MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 12/27/61
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem
22d. LOCATION (City, town, or county) (State): Bladensburg PG Md

23. FUNERAL DIRECTOR'S SIGNATURE: Cherry Chase Funeral Home
ADDRESS: 5103 Wis Ave NW Wash D.C.

24a. REC'D BY REGISTRAR DATE: DEC 26 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Frame

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14162 Item 23c, Film G304 1/3/62 jwk 14131

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs 1651-2
d. STREET ADDRESS: 8305 12th Avenue
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Janet Middle: Mary Last: MacLean
4. DATE OF DEATH: Month: December Day: 28, Year: 1961
5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: March 19, 1901
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Inverness, Scotland
12. CITIZEN OF WHAT COUNTRY? England
13. FATHER'S NAME: Thomas Perry
14. MOTHER'S MAIDEN NAME: Margaret Monroe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: DAUGH: Mrs. Margaret Asher, Same as #2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that [X] (this hospital) attended the deceased from Dec. 28, 1961, to Dec. 28, 1961 that ([X] (we) last saw the deceased alive on Dec. 28, 1961 and that death occured at 11:55 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert E. DeForest M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: December 28, 1961
22c. PHYSICIAN'S NAME (Type): ROBERT E. DEFOREST LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1-2-62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery George Washington Cem.
23d. LOCATION (City, town or county) (State): Rockville, Maryland P.G. County

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Miska
ADDRESS: S.S., Md.
Warner Pumphrey Funeral Home, 8434 Ga., AVe.,
25a. REC'D BY REGISTRAR: DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Irving S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14163

CERTIFICATE OF DEATH

14132

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Gardens Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): McLean 83X-3
d. STREET ADDRESS: 4410 N. Chesterbrook Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Perrin — Last: Mangan
4. DATE OF DEATH: Month: Dec. — Day: 11 — Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 8, 1877
9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Executive
10b. KIND OF BUSINESS OR INDUSTRY: Potomac Electric Co.
11. BIRTHPLACE (State or foreign country): Richmond, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph T. Mangan
14. MOTHER'S MAIDEN NAME: Nora Perrin
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-09-3690
17. INFORMANT: Rosa Mangan Kirby — Address: McLean, Va. 4410 Chesterbrook Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO (b): Senanitis — Hours
DUE TO (c): Arteriosclerosis — 20+ yrs.

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12-4-40, 19__, to 12/11/61, 19__, that (I) (~~we~~) last saw the deceased alive on 12-17-61, and that death occurred at 9:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: E. H. Aschenbach, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/11/61
22c. PHYSICIAN'S NAME (Type): E. H. Aschenbach
22d. ADDRESS: 1841 Col Rd NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-14-1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Francis Sonnenberg
ADDRESS: 1756 Pa. Ave. NW. Wash. DC
25a. REC'D BY REGISTRAR: DATE DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14164

CERTIFICATE OF DEATH

14133

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 2 M X I 0 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Yorktown Village
c. LENGTH OF STAY IN 1b: 22 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5021 Worthington Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Yorktown Village 56
d. STREET ADDRESS: 5021 Worthington Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: MARION Middle: CATHERINE Last: MANN

4. DATE OF DEATH: Month: Dec Day: 27 Year: 1961

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☑ **DIVORCED** ☐

8. DATE OF BIRTH: April 29, 1890

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Melchior

14. MOTHER'S MAIDEN NAME: Grace Steiner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: H.W. MANN Address: 5021 - Worthington Dr. Yorktown Village Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause on line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from March, 1959 to Dec 27, 1961, that (I) (~~last~~) last saw the deceased alive on Dec 27 1961, and that death occured at 11:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Harry N Carlton, M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): HARRY N. CARLTON

22d. ADDRESS: 940-25th St, N.W. Wash 7, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/29/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Prince Georges Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S. H. Hines Company ADDRESS: Washington, D.C.

25a. REC'D BY REGISTRAR DATE DEC 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Flemma

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14165 14134

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 5 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Md
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 10003 Clue Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen — Middle: L — Last: Manno

4. DATE OF DEATH: Month: Dec — Day: 16 — Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3/13/28
9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR: Months 9, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Chester PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fury Oleksey
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Korean War
16. SOCIAL SECURITY NO.:
17. INFORMANT: Husband — Joseph R. Manno — Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — 24 HRS.
DUE TO (b): THROMBOCYTOPENIA — 2 MOS.
DUE TO (c): ACUTE MYELOCYTIC LEUKEMIA — 2 MOS.

204.3

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from DEC. 2, 1961, to DEC. 16, 1961, that (I) (~~we~~) last saw the deceased alive on DEC. 16, 1961, and that death occured at 4:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John H. Tuohy M.D.
22b. DATE SIGNED: 12-16-61
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. PHYSICIAN'S NAME (Type): J. H. TUOHY, M.D.
22d. ADDRESS: 7720 WISCONSIN AVE BETHESDA 14, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/19/61
23c. NAME OF CEMETERY OR CREMATORY: Emaculate Cem.
23d. LOCATION (City, town or county) (State): Chester, Pennsylvania

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR: DATE DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Trowa

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14166

CERTIFICATE OF DEATH

14136

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakhaven Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 22 Silver Spring
d. STREET ADDRESS: 9411 Colesville Road.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: ~~XXXXXXXX~~ BERTIE; Middle: P.; Last: Mason
4. DATE OF DEATH: Month: Dec; Day: 9; Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 15, 1875
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William Plumley
14. MOTHER'S MAIDEN NAME: Susan RICHMOND
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MR. RICHARD F. MASON — Address: 9411 COLESVILLE ROAD SILVER SPRING, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
493X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized arteriosclerosis. Uremia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug, 1955 to Dec 9, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec 8 1961, and that death occured at 9:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Seruth T. Kimble. M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 9 Dec 61.
22c. PHYSICIAN'S NAME (Type): SERUTH T. KIMBLE
22d. ADDRESS: 927 Pershing Drive Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY
23d. LOCATION (City, town or county) (State): MONTGOMERY MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Bernard B. Zaska — ADDRESS: 8434 GEORGIA AVENUE
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND
25a. REC'D BY REGISTRAR — DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14167 **CERTIFICATE OF DEATH** 14137

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: six days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring 16 57-2
d. STREET ADDRESS: 8500 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: Marjorie Last: Mathis

4. DATE OF DEATH: Month: Dec Day: 18 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 11-20-18

9. AGE (In years last birthday): 43 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Exec. Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Wm. E. Richardson

11. BIRTHPLACE (County & State, or foreign country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Mathis

14. MOTHER'S MAIDEN NAME: Emma Sue Maroney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 426-03-7472

17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days.

331X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 12 Dec, 19__, to 18 Dec, 1961, that (I) (~~we~~) last saw the deceased alive on 17 Dec 1961, and that death occured at 8:05 A.M, from the causes and on the date stated above.

22a. SIGNATURE: H B Queen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 18 Dec 1961

22c. PHYSICIAN'S NAME (Type): H. B. QUEEN M.D.

22d. ADDRESS: 7112 Willow Ave Takoma Park, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/21/61

23c. NAME OF CEMETERY OR CREMATORY: Harris Cemetery

23d. LOCATION (City, town or county) (State): Carthage, Mississippi

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Ziska ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.

25a. REC'D BY REGISTRAR DATE: DEC 20 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14169

CERTIFICATE OF DEATH

14139

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 74 I 0 1

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: XXXXXXXXXXXXXX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X.3
d. STREET ADDRESS: 4000 Massachusetts Avenue
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daniel — Middle: J. — Last: McGill

4. DATE OF DEATH: Month: Dec. — Day: 28, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 3-31-98

9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Edward McGill

14. MOTHER'S MAIDEN NAME: Mary Linskey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 577-10-5058

17. INFORMANT: Annie P. McGill, wife — Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.
420.0
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — 2 yrs known
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-26, 1961 to 12-28, 1961, that (I) (we) last saw the deceased alive on ~~[illegible]~~ 12/28 RHP 1961, and that death occured at 8 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard H Pollen M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): RICHARD H. POLLEN, M.D.

22d. ADDRESS: 10511 SUMMIT AVE KENSINGTON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-30-61

23c. NAME OF CEMETERY XXXXXXXX: Mount Olivet

23d. LOCATION (City, town or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis J. Collins — ADDRESS: 3821-14th St. N.W. Wash. D.C.

25a. REC'D BY REGISTRAR: DATE JAN 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14170 **CERTIFICATE OF DEATH** 14140

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 74 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Point Marion 75X·3
d. STREET ADDRESS: 201 Boulevard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Everett; Middle: Laing; Last: McGill
4. DATE OF DEATH: Month: December; Day: 5; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 18 May 1911
9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph N. McGill
14. MOTHER'S MAIDEN NAME: Jennie Laing
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 204-10-9999
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 12 days
DUE TO (b) Carcinoma of the lung with cerebral, hepatic and probable cardiac metastoses. — 1 year
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (X) (this hospital) attended the deceased from September 22 1961, to Dec. 5, 1961, that (I) (we) last saw the deceased alive on Dec. 5 1961, and that death occured at 11:45 AM from the causes and on the date stated above.

22a. SIGNATURE: John C. Marsh M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): John C. Marsh, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY:
23d. LOCATION (City, town or county) (State): SMITHFIELD, PENNA.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 1400 Chapin St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14171 14141

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b: 0 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 0210-2
d. STREET ADDRESS: 715 Sprindale Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Richard Middle Gordon Last Messer
4. DATE OF DEATH: Month December Day 29 Year 1961
5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 22 November 1903
9. AGE (In years last birthday): 58 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Coast Guard Retired Buyer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Messer
14. MOTHER'S MAIDEN NAME: Carrie Huff
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes (If yes give year or dates of service): 1920-1945
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Mary E. MESSER, Address: Annapolis, Maryland, 715 Sprindale Ave.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dissecting Aortic Aneurysm
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

451X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from 29 December 1961 to 29 December 1961 that XX (we) last saw the deceased alive on 29 December 1961, and that death occured 805PM, from the causes and on the date stated above.

22a. SIGNATURE: A T Thorp Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. XX
22b. DATE SIGNED: Dec. 30, 1961
22c. PHYSICIAN'S NAME (Type): A. T. THORP JR. LT MC USN
22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/2/62
23c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF
23d. LOCATION (City, town or county) (State): ANNAPOLIS MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons
ADDRESS: JOHN M. TAYLOR AND SONS ANNAPOLIS, MARYLAND
25a. REC'D BY REGISTRAR DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
1SM 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14172 **CERTIFICATE OF DEATH** 14142

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 09 Rockville
d. STREET ADDRESS: 1 606 Edmonston Dr.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles Middle: Lester Last: Messick

4. DATE OF DEATH: Month: December Day: 4, Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/28/1894
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Messick
14. MOTHER'S MAIDEN NAME: Elizabeth Biller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 578-09-2357
17. INFORMANT: wife, Cordelia Messick-Same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH

IMMEDIATE CAUSE (a) Cardiac Tamponade — 4 hrs.
DUE TO (b) Rupture, left ventricle — 1 hr.
DUE TO (c) Myocardial infarct — —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/1/61, 1961, to 12/4/61, 1961, that (I) (we) last saw the deceased alive on 12/4/61, 1961, and that death occured at 10:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Stephen N. Jones M.D. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/5/61
22c. PHYSICIAN'S NAME (Type): Stephen N. Jones, M.D.
22d. ADDRESS: 809 Viers Mill Rd. Rockville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14173 **CERTIFICATE OF DEATH** 14143

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Chevy Chase
d. STREET ADDRESS: 4716 Bradley Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sylvester; Middle: ; Last: Mettenburg
4. DATE OF DEATH: Month: December; Day: 2; Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10/16/98
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Accountant
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (County & State, or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Conrad Mettenburg
14. MOTHER'S MAIDEN NAME: Anna Hellweg
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Joseph A. Cantrel (Executor) — Address: 808 17th St. NW. Washington 6, D.C.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
42011

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 30, 1961 to Dec 2, 1961, that (I) (we) last saw the deceased alive on 12/1/61, and that death occured at 10:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. P. Joyce M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/2/61
22c. PHYSICIAN'S NAME (Type): W. P. Joyce
22d. ADDRESS: 8106 Maple Ridge Road, Bethesda, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Tran
23b. DATE THEREOF: 12/5/61
23c. NAME OF CEMETERY OR CREMATORY: St. Johns Church Cem.
23d. LOCATION (City, town or county) (State): Houghton, Iowa

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

4

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14168 14138

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Simpsonville (Clarksville)
d. STREET ADDRESS: 13X-2
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Grace — Middle: Elizabeth — Last: Meyers

4. DATE OF DEATH: Month: 12 — Day: 23 — Year: 1961

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/3/1899 or 1900
9. AGE (In years last birthday): 61-62
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): hswf.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Henry Wilson
14. MOTHER'S MAIDEN NAME: Elizabeth Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
DUE TO (b) Encephalomalacia, left — 10 days
DUE TO (c) Thrombosis, left middle cerebral — 3 weeks

332 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: John P Martin — John P Martin M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAT PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-28-61
23c. NAME OF CEMETERY OR CREMATORY: Hopkins Church
23d. LOCATION (City, town or county): Highland, Md. (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
25a. REC'D BY REGISTRAR: DATE JAN 5 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 73 I 0 1 8

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14174 14144

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Buck Lodge
c. LENGTH OF STAY IN (b): 6 ~~years~~ months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Simpson Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Cedar Grove Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Jesse Middle Alby Last Miles
4. DATE OF DEATH: Month December Day 31 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 26, 1877
9. AGE (In years last birthday): 84 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George Miles
14. MOTHER'S MAIDEN NAME: Ella Beal
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Ella M. Bosley Address: Rockville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO (b) Cerebral Arteriosclerosis — 2 years
DUE TO (c) Arteriosclerotic-Hypertensive Cardiovascular Disease — 10 year

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 29 July 1961, to 31 Dec 1961, that (I) (we) last saw the deceased alive on 31 Dec 1961, and that death occurred at 8:40 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Gordon M. Smith M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2 Jan 62
22c. PHYSICIAN'S NAME (Type): Gordon M. Smith, M.D
22d. ADDRESS: Barnesville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 3, 1962
23c. NAME OF CEMETERY OR CREMATORY: Salem
23d. LOCATION (City, town, or county) (State): Cedar Grove, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE: JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14175 14145

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Congressional Manor Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 54 Chevy Chase
d. STREET ADDRESS: 4404 Ridge Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Sarah Middle Hays Last Miley
4. DATE OF DEATH: Month Dec. Day 15, Year 1961
5. SEX: Fe.
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Jan. 29 1869
9. AGE (In years last birthday): 92 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alfred Mordecai
14. MOTHER'S MAIDEN NAME: Sallie Maynadier
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. N. M. Asbburner-daughter-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
DUE TO
(b) Cerebral Arteriosclerosis
DUE TO
(c) Bronchopneumonia

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 1 1958 to Dec 15 1961, that (I) (we) last saw the deceased alive on Dec 13 1961, and that death occurred at 7:30 PM from the causes and on the date stated above.

22a. SIGNATURE: William Henry Killax M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/15/61
22c. PHYSICIAN'S NAME (Type): William Henry Killax
22d. ADDRESS: 8218 Wisconsin Av Bethesda 14 Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12/19/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town, or county) (State): Suitland, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14176 Item 9 Film 0303 12/26/61 mh 14176

1. PLACE OF DEATH
a. COUNTY: Montgomery (MARYLAND)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park,
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 35 Silver Spring,
d. STREET ADDRESS: 11805 Idlewood Road,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75

3. NAME OF DECEASED (Type or print): First / Middle / Last: Miller

4. DATE OF DEATH: Month December, Day 9, Year 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 9, 1961
9. AGE (In years lost birthday) yrs.; IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no
10b. KIND OF BUSINESS OR INDUSTRY: no
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: America

13. FATHER'S NAME: George Preston Miller
14. MOTHER'S MAIDEN NAME: Frances Annette Sykes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: father Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
(b) VASCULAR COLLAPSE — FEW HOURS
DUE TO
(c) PLACENTAL SEPARATION — FEW HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

761.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AFTER BIRTH 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 2:14 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert L. Krichmar M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Robert L. Krichmar, M. D.
22d. ADDRESS: 7733 Alaska Avenue, N.W. Washington, D.C.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-9-61
23c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hospital, Takoma Park, Md.
23d. LOCATION (City, town, or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M. D.
ADDRESS: Washington Sanitarium and Hospital
25a. REC'D BY REGISTRAR DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

— 2075254150

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14177

Reg. Dist. No. 1417

1. PLACE OF DEATH
a. COUNTY: Mpntgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4214 Brookfield Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 43 Kensington
d. STREET ADDRESS: 4214 Brookfield Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen; Middle: P; Last: Miller

4. DATE OF DEATH: Month: December; Day: 13; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/15/91

9. AGE (In years last birthday): 70 yrs. — IF UNDER 1 YEAR: Months: 8; Days: 28; Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Schools, fet

10b. KIND OF BUSINESS OR INDUSTRY: Teacher

11. BIRTHPLACE (State or foreign country): Deleware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank M. Stoever

14. MOTHER'S MAIDEN NAME: (Unknown) Price

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Yes-Unknown

INFORMANT: J. W. Belt-Son in law-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ADENOCARCINOMA OF RECTUM — INTERVAL BETWEEN ONSET AND DEATH: 4 MONTHS
154X
DUE TO (b): WITH METASTASES
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from APRIL, 1957, to DECEMBER 13 1961, that I last saw the deceased alive on DECEMBER 13 1961, and that death occurred at 2:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert L. Krichmar M.D. — ADDRESS (Street, city or town, state): 7733 ALASKA AVENUE N.W. WASHINGTON 12 D.C. — DATE SIGNED: DEC. 13 1961

PHYSICIAN'S NAME (Type): ROBERT L. KRICHMAR

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/16/61

22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

24a. REC'D BY REGISTRAR — DATE: DEC 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [redacted] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH

14148

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14178

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Spencerville
c. LENGTH OF STAY IN 1b: five years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Thompson Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Spencerville
d. STREET ADDRESS: Thompson Road 14 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle LUTHER — Last MINNICK

4. DATE OF DEATH: Month December — Day 17 — Year 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 10, 1880

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - selfemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James D. Minnick

14. MOTHER'S MAIDEN NAME: ~~XXXX~~ Chewning

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 218-38-7758

17. INFORMANT: Mr. Walter Minnick — Address: Thompson Road, Spencerville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudd death in Tel
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DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/20/61
22c. NAME OF CEMETERY OR CREMATORY: New Hope Baptist Cemetery
22d. LOCATION (City, town, or country) (State): Orange County, Virginia

23. FUNERAL DIRECTOR: Raymond A. Ziska — ADDRESS: 8434 Georgia Avenue, Silver Spring, Maryland
Warner E. Pumphrey, Inc.

24a. REC'D BY REGISTRAR DATE: DEC 20 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14179 **CERTIFICATE OF DEATH** 14149

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WHEATON
c. LENGTH OF STAY IN 1b: 21 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Silver Spring
d. STREET ADDRESS: 8712 Colesville Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EVELYN Middle: HOLLAND Last: MONROE
4. DATE OF DEATH: Month 12 Day 8 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-23-1870
9. AGE (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES HOLLAND
14. MOTHER'S MAIDEN NAME: Margaret Flenner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Frank J. Rapee — Address: 8712 Colesville Road Silver Spring, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days
332 X
DUE TO (b): Cerebral Arteriosclerosis — 4-5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 3, 1961, to Dec 8, 1961, that (I) (we) last saw the deceased alive on Dec 7, 1961, and that death occured at 2:37 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Neil P. Campbell M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/61
22c. PHYSICIAN'S NAME (Type): Neil P. Campbell
22d. ADDRESS: Kenesaw Apt

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/11/61
23c. NAME OF CEMETERY OR CREMATORY: GLENWOOD CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond W. Biska
WARNER E. PUMPHREY, INC.
ADDRESS: 8434 GEORGIA AVENUE SILVER SPRING, MARYLAND
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Knauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible]pletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14180 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14150

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): ~~xxxxxxxx~~Chevy Chase
c. LENGTH OF STAY IN 1b: 1 yr
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4411 Walsh Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 54 x Chevy Chase
d. STREET ADDRESS: 4411 Walsh St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Matthias Middle Paul Last Monson
4. DATE OF DEATH: Month Dec Day 31 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-12-28
9. AGE (In years last birthday): 33 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physicist
10b. KIND OF BUSINESS OR INDUSTRY: F.A.A.
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Matthias Monson
14. MOTHER'S MAIDEN NAME: Mary Peterson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Patricia Monson (wife) Address: Stem 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): hanging
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

974X

INTERVAL BETWEEN ONSET AND DEATH: Found hanging in garage, at home

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 12-31-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 1/3/62
22c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
22d. LOCATION (City, town, or country) (State): Arlington, Virginia

23. FUNERAL DIRECTOR: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS
24a. REC'D BY REGISTRAR DATE: JAN 3 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14181 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14151

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: ~~6913~~ 8619 Piney Br. Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isaac Middle: Roland Last: Moore
4. DATE OF DEATH: Month: 12 Day: 4 Year: 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-31-92
9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Isaac Moore
14. MOTHER'S MAIDEN NAME: ~~Annie~~ SUSAN Miles
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW I - Army
16. SOCIAL SECURITY NO.: 578 14 5616
17. INFORMANT: James E. Moore Address: 138 E ST S E DC

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): History of previous coronary disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-4-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 7, 1961
22c. NAME OF CEMETERY OR CREMATORY: Burtonsville Union Cemetery
22d. LOCATION (City, town, or country) (State): Montgomery Co., Maryland

23. FUNERAL DIRECTOR: Raymond A. Ziska ADDRESS: Silver Spring, Md.
WARNER E. PUMPHREY, INC. 8434 Georgia Ave.
24a. REC'D BY REGISTRAR DATE: DEC 6 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kirwa

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14182 14152

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 9 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6101 DUNLEER COURT

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
a. STATE: OHIO
b. COUNTY: CUYAHOGA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEREA
d. STREET ADDRESS: 201 S. ROCKY RIVER DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: EDNA Middle: STEWART Last: MORGAN

4. DATE OF DEATH: Month: DECEMBER Day: 5 Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: CAUCASOID

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 5, 1893

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OFFICE WORKER

10b. KIND OF BUSINESS OR INDUSTRY: REAL ESTATE

11. BIRTHPLACE (County & State, or foreign country): POLAND, OHIO MAHONING COUNTY

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: DAVID HAMMOND STEWART

14. MOTHER'S MAIDEN NAME: SARAH FRANCES GIESE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 299-20-3258

17. INFORMANT: MRS. HOMER THRALL — Address: 6101 DUNLEER CT. BETHESDA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHYXIA; PULMONARY EDEMA — INTERVAL BETWEEN ONset AND DEATH: 15 MINUTES
DUE TO (b): CONGESTIVE HEART FAILURE — 15 WEEKS
DUE TO (c): MYOCARDIAL INFARCTION — 15 WEEKS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20e. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from NOV. 27, 1961 to DEC. 5, 1961, that (I) (~~we~~) last saw the deceased alive on DEC. 4, 1961, and that death occured at 7 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Joseph D. Connor, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: DEC. 5, 1961

22c. PHYSICIAN'S NAME (Type): JOSEPH D. CONNOR
22d. ADDRESS: 9420 OLD GEORGETOWN RD BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
23b. DATE THEREOF: 12/6/61
23c. NAME OF CEMETERY OR CREMATORY: Lake Park Cemetery
23d. LOCATION (City, town or county) (State): South Youngstown, Ohio

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR: DEC 7 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14183

CERTIFICATE OF DEATH

Reg. Dist. No. 14153

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b NB
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOYDS
d. STREET ADDRESS Box 268 Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: BABY Middle: BOY Last: MORTON

4. DATE OF DEATH Month: DECEMBER Day: 6 Year: 1961

5. SEX MALE
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC. 6. 1961
9. AGE (In years lost birthday) yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours 7 Min. 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BOBBY GENE MORTON
14. MOTHER'S MAIDEN NAME AGNES LILLIAN BREEDEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT MOTHER Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ATELECTASIS, INTRACRANIAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 7 hr 57 min
762.5
DUE TO
(b) PREMATURITY — 7 hr 57 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC. 6, 1961, to DEC 6, 1961, that I last saw the deceased alive on DEC 6, 1961, and that death accurred at 7:00 PM, fram the causes and an the date stated abave.

ACTUAL SIGNATURE Theodore H. Anders M.D. — ADDRESS (Street, city or town, state) 4700 Bradley Blvd Chevy Chase, Md — DATE SIGNED 12-6-61

PHYSICIAN'S NAME (Type) THEODORE H. ANDERS

22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION
22b. DATE THEREOF 12-7-61
22c. NAME OF CEMETERY OR CREMATORY SUBURBAN HOSPITAL
22d. LOCATION (City, town, or county) (State) BETHESDA, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE Amelia C. Carter, Admin. (per FB) — ADDRESS Suburban Hosp. Bethesda, Md.
24a. REC'D BY REGISTRAR DATE DEC 20 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

2074171XV3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14184

CERTIFICATE OF DEATH

14154

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY COUNTY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA (KENWOOD, MD.)
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6416-SHADOW ROAD, KENWOOD, MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENWOOD ~~BETHESDA~~, MARYLAND
d. STREET ADDRESS: 6416-SHADOW ROAD, KENWOOD, MARYLAND
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLIAN Middle L. Last MOSES

4. DATE OF DEATH: Month Dec. Day 31 Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 25, 1884

9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months 11, Days 6 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME-MAKER

11. BIRTHPLACE (County & State, or foreign country): WASHINGTON, DIST. OF COL.

12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: JAMES T. HOWENSTEIN

14. MOTHER'S MAIDEN NAME: MARY WADE SULLIVAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Daughter): MRS. PATRICIA RICHARDS — Address: ARLINGTON, VA. 2785-FT. SCOTT DRIVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Cerebral arteriosclerosis — 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive - Cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from July 27, 1961, to Dec. 30, 1961, that (I) ~~(we)~~ last saw the deceased alive on Dec 30 1961, and that death occured at 1:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Malcolm D. Harrison M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Dec. 31, 1961

22c. PHYSICIAN'S NAME (Type): MALCOLM D. HARRISON

22d. ADDRESS: 4535 YUMA ST NW - WASH. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 1/3/1962

23c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CREMATORY

23d. LOCATION (City, town or county) (State): PRINCE GEORGES, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Martin W. Hysong Co. — ADDRESS: 1300 N. St, N.W. WASHINGTON, D.C.

25a. REC'D BY REGISTRAR DATE: JAN 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(17)

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14185 14155

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marylander Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Dist. of Col. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X-3
d. STREET ADDRESS: 4620 Butterworth St., N.W.
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Jane Middle Last Mullikin
4. DATE OF DEATH: Month Dec. Day 6 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9-29, 1864
9. AGE (In years last birthday): 97 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Burgess
14. MOTHER'S MAIDEN NAME: Elizabeth Cannon
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - (If yes, give war or dates of service) - -
16. SOCIAL SECURITY NO.: - - -
17. INFORMANT: Annie Wood, 4620 Butterworth St. N.W. Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4 22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct. 10, 1959 to Dec. 6, 1961, that (I) last saw the deceased alive on Dec. 4 1961, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: James R. Kerr M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Damascus, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-8-1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Washington, D. C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Lawrence Dowling ADDRESS: 1756 Pa. Ave. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE DEC 8 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hawes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14186

CERTIFICATE OF DEATH

14156

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 1119 CLAGETT DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: BELVA Middle: M Last: MULLINS

4. DATE OF DEATH: Month: DEC. Day: 7 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/12/14

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: LEVI BOGGS

14. MOTHER'S MAIDEN NAME: GOLDIE BERRY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO
(b) CEREBRAL ARTERIOSCLEROSIS — 5 years
DUE TO
(c) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE — 20 YRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CORONARY THROMBOSIS - DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from AUGUST, 1961, to DECEMBER 7, 1961, that (I) (we) last saw the deceased alive on DECEMBER 7, 1961, and that death occured at 6:10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Gordon S. Rosenberger M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: December 7, 1961

22c. PHYSICIAN'S NAME (Type): GORDON ROSENBERGER

22d. ADDRESS: 310 W. Montg. Ave. Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/10/62

23c. NAME OF CEMETERY OR CREMATORY: Meade

23d. LOCATION (City, town or county) (State): Pound, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Byron Wheeler — ADDRESS: 133 E. Montg. Ave., Rockville, Md.

25a. REC'D BY REGISTRAR DATE DEC 13 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14187

CERTIFICATE OF DEATH

14157

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Brookmont
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4103 Maryland Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brookmont 5 yr
d. STREET ADDRESS: 4103 Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Josephine; Middle: Ellen; Last: Mutchler

4. DATE OF DEATH: Month: Dec.; Day: 20; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Nov. 8, 1875

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William E. Burroughs

14. MOTHER'S MAIDEN NAME: Mary Alice Frizzell.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Ida Johnson, Sister, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c) Generalized arteriosclerosis — years

331X

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July, 19 58 to Dec 20, 19 61, that (I) (we) last saw the deceased alive on Dec 20 19 61, and that death occured at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Andrew Tessitore M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12-20-61

22c. PHYSICIAN'S NAME (Type): ANDREW TESSITORE

22d. ADDRESS: 114 Courthouse Rd SW Vienna Va

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 23, 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l.

23d. LOCATION (City, town or county) (State): Ft. Myer, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.

ADDRESS: 3072-M St. N.W. Wash., D.C.

25a. REC'D BY REGISTRAR DATE: DEC 27 61

25b. REGISTRAR'S SIGNATURE: Clifford S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14188 **CERTIFICATE OF DEATH** 14158

Items 13 & 14 Film G302 12/11/61 1wk

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 16 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: OHIO
b. COUNTY: ~~MONTGOMERY~~
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): URBANA ~~URBANA~~
d. STREET ADDRESS: 216 BOYCE ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OLIVE Middle LEE Last MYERS

4. DATE OF DEATH: Month DEC. Day 3 Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/16/75
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~None~~ HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): OHIO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Drewey ~~UNKNOWN~~ Smith
14. MOTHER'S MAIDEN NAME: ~~UNKNOWN~~ Sarah Jane Hart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Mr. Clarence Myers — Address: 1205 Teldon Street Wheaton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, posterior wall — INTERVAL BETWEEN ONSET AND DEATH: About 10 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov 25, 1961 to Dec 3, 1961, that (I) (we) last saw the deceased alive on Dec 3 1961 and that death occured at 3:35 AM from the causes and on the date stated above.

22a. SIGNATURE: John J Curry M.D. — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): JOHN J. CURRY
22d. ADDRESS: 10,620 GEORGIA AVENUE, SILVER SPRING, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: GLEN HAVEN CEMETERY
23d. LOCATION (City, town or county) (State): SPRINGFIELD, CLARK CO, OHIO

24 FUNERAL DIRECTOR'S SIGNATURE: Wayne E. Bumpers — ADDRESS: 8434 GEORGIA AVENUE SILVER SPRING, MARYLAND
25a. REC'D BY REGISTRAR DATE DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14189 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14159

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 5 yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 4515 Gridley Rd.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 35 Wheaton
d. STREET ADDRESS: 4515 Gridley Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Ketchem Last Nehmeus
4. DATE OF DEATH: Month Dec. Day 18 Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-15-1890
9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): plumber
10b. KIND OF BUSINESS OR INDUSTRY: PLUMBING
11. BIRTHPLACE (State or foreign country): N.Y.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Nehmeus
14. MOTHER'S MAIDEN NAME: Elizabeth Raymond
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: ——
17. INFORMANT: Edith Gilbert (daughter) Address: Silver

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/21/61
22c. NAME OF CEMETERY OR CREMATORY: Cypress Hills
22d. LOCATION (City, town, or country) (State): Brooklyn New York

23. FUNERAL DIRECTOR: Raymond A. Ziska ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland
24a. REC'D BY REGISTRAR DATE: DEC 22 '61
24b. REGISTRAR'S SIGNATURE: Carlton S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14190 14160

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where decaased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 47 Chevy Chase
d. STREET ADDRESS: 1 5124 Bradley Boulevard
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise Middle: Newkirk Last: Nelson

4. DATE OF DEATH: Month: December Day: 7, Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/26/09
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis M. Newkirk
14. MOTHER'S MAIDEN NAME: Verda Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: None
17. INFORMANT: M. Cary Nelson, husband Address: same as above

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of breast with widespread metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
170X
DUE TO (b)
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11-10-, 1961, to 12-7-, 1961, that (I) (we) last saw the deceased alive on 12-7- 19 61, and that death occured at 3:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Stephen W. Dejter M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/7/61
22c. PHYSICIAN'S NAME (Type): Dr. S. Wm. Dejter
22d. ADDRESS: 6719 Wilson Lane, Beth. Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/11/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14191 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14161

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton SILVER SPRING
c. LENGTH OF STAY IN 1b: 12 yr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 11801 Judson Rd

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 37 Wheaton
d. STREET ADDRESS: 11801 Judson Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ollie — Middle: Ethel — Last: Newcomb

4. DATE OF DEATH: Month: Dec — Day: 6 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1-1-1893
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lee G. Smith
14. MOTHER'S MAIDEN NAME: Margaret O Brien

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: Emmit Combs — Address: Thurm

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed
420.1
DUE TO (b):
Conditions, if any, which geva rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Bruschart M.D.
EXAMINER'S NAME (Type): FRANK J. BRUSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 12/9/61
22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEMETERY
22d. LOCATION (City, town, or country) (State): PRINCE GEORGE'S MARYLAND

23. FUNERAL DIRECTOR: Raymond A Ziska — ADDRESS: 8434 GEORGIA AVENUE
WARNER E. PUMPHREY, INC. SILVER SPRING, MARYLAND

24a. REC'D BY REGISTRAR — DATE: DEC 8 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14192

CERTIFICATE OF DEATH

14162

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 29 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U. S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Key West — 48X-3
d. STREET ADDRESS: 330 Duval Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Ellen — Last: Nicholson

4. DATE OF DEATH: Month: December — Day: 28, — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 15, 1930

9. AGE (In years last birthday): 31 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Schenectady, N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Bryant Halsey

14. MOTHER'S MAIDEN NAME: Emma Blaise

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 111-28-5579

17. INFORMANT: HUS: William Nicholson, Same as #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Mitral Stenosis — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs
DUE TO (b): Rheumatic Heart Disease — 16 yrs
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from Nov. 29, 1961 to Dec. 28, 1961, that ☒ (we) last saw the deceased alive on Dec. 28, 19 61, and that death occured 11:35 AM from the causes and on the date stated above.

22a. SIGNATURE: C W Bramlett M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Dec. 28, 1961

22c. PHYSICIAN'S NAME (Type): C. W. BRAM LETT LT MC USN

22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12-30-61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler — ADDRESS: Tyson Wheeler Funeral, Rockville, Maryland

25a. REC'D BY REGISTRAR: DATE JAN 2 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

Montgomery Florida

Bethesda (Naval) 29 days Key West

U. S. Naval Hospital 320 Duval Street

Mary Allen Nicholson December 20,

Female Caucasian November 15,1950 21

Housewife Schenectady, N.Y. USA

Bryant Bailey Emma Blake

No - - - - 111-28-5575 HUS: William Nicholson, Dame an 42

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14193 **CERTIFICATE OF DEATH** 14163

Item 7 10/10/62 filed #324-AC

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland 13x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ellen Virginia O'Brien; Middle; Last
4. DATE OF DEATH: Month 12; Day 6; Year 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/12/1900
9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months; Days — IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bowker
14. MOTHER'S MAIDEN NAME: Cora May Golden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia + Anemia — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b) Acute + Chronic pyelonephritis — 3 mo
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
600.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): -
20c. TIME OF INJURY: Hour a.m. p.m. - Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -
20f. (City or town) (County) (State): -

21. **I certify** that (I) (this hospital) attended the deceased from 2/3 1960 to 12/6 1961, that (I) (we) last saw the deceased alive on 12/6 1961, and that death occured at 6:50 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/8/61
22c. PHYSICIAN'S NAME (Type): Dr. Charles Ligon
22d. ADDRESS: Sandy Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-9-61
23c. NAME OF CEMETERY OR CREMATORY: GATE OF HEAVEN
23d. LOCATION (City, town or county) (State): WHEATON. Md

24. FUNERAL DIRECTOR'S SIGNATURE: F C Rigmothers — ADDRESS: Ellicott City Md.
25a. REC'D BY REGISTRAR: DATE DEC 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14194 14164

M

1. PLACE OF DEATH
a. COUNTY: Mont. County — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney, Md
c. LENGTH OF STAY IN 1b: 7 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
a. STATE: Maryland
b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Brookeville, Md.
d. STREET ADDRESS: Brookeville, Md.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

90

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3. NAME OF DECEASED (Type or print): First: Carrie — Middle: — Last: Oland

4. DATE OF DEATH: Month: DEC. Day: 26 Year: 1961

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1872
9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Fred. Co. Md.
12. CITIZEN OF WHAT COUNTRY? Amer.

13. FATHER'S NAME: David Specht
14. MOTHER'S MAIDEN NAME: Aurelia Kesseller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Margaret O Howes — Address: Olney Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO (b): Chronic pyelonephritis — 1 yr
DUE TO (c): Arteriosclerosis General — 7 yrs

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct 1958, to 12/26 1961, that (I) (we) last saw the deceased alive on 12/12 1961, and that death occured at 7:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: C. H. Bigon M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/26/61
22c. PHYSICIAN'S NAME (Type): C. H. Bigon
22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, (Specify): Burial
23b. DATE THEREOF: Dec. 29 1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel
23d. LOCATION (City, town or county) (State): Montgomery Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
15M 7/61

1

FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14195 14165

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 14 Silver Spring
d. STREET ADDRESS: 14350 Good Hope Rd.
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First — MICHAEL; Middle — HUMPHREY; Last — O'LEARY
4. DATE OF DEATH: Month — Dec.; Day — 17; Year — 19 61
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ]
8. DATE OF BIRTH: 1/22/04
9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 1
10b. KIND OF BUSINESS OR INDUSTRY: Landscaping
11. BIRTHPLACE (State or foreign country): Ireland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Michael O'Leary
14. MOTHER'S MAIDEN NAME: Julia O'Brien
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Second W.W.
16. SOCIAL SECURITY NO.: 216-01-9953
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Rupture of aorta
DUE TO (c)
981X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [X] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Shot in chest with 22 Cal. Rifle
20c. TIME OF INJURY: Hour 5:30 a.m. p.m. — Month, Day, Year 12/17/61
20d. INJURY OCCURRED: While at work [ ] Not While at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State): Silver Spring, Md.

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 12/18/61
EXAMINER'S NAME (Type): Frank J. Broschart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/21/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country) (State): Arlington, Va.
23. FUNERAL DIRECTOR: Francis Gasch's Sons — ADDRESS: Hyattsville, Maryland
24a. REC'D BY REGISTRAR — DATE: DEC 21 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14196

CERTIFICATE OF DEATH

Reg. Dist. No. 13166

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boyds--R.F.D
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Boyds-R.F.D
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HiLLebrand Middle: Last: OLTHUIS

4. DATE OF DEATH: Month: December Day: 24 Year: 1961

5. SEX: Male ~~Female~~

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 15-1908

9. AGE (In years last birthday): 53 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk--Montg.Co.School Board,Md

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Holland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Tgaart Olthuis

14. MOTHER'S MAIDEN NAME: Klaasji Van Dalen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 215-38-4689

INFORMANT: Mrs Mary Simpson, Boyds, Md.R.F.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Bronchogenic Carcinoma — 6 months.
DUE TO
(c):

162.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 Dec 1961, to 24 Dec 1961, that I last saw the deceased alive on 23 Dec 1961, and that death occurred at 2.30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John G. Fawcett M.D. — ADDRESS (Street, city or town, state): Boyds, Md.R.F.D. — DATE SIGNED: 12/24/61

PHYSICIAN'S NAME (Type): John Fawcett

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12/26/61

22c. NAME OF CEMETERY OR CREMATORY: Flower Hill Cemetery

22d. LOCATION (City, town, or county) (State): Deerwood, R.F.D. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: William B. Hilton — ADDRESS: Barnesville, Md

24a. REC'D BY REGISTRAR DATE: DEC 28 '61

24b. REGISTRAR'S SIGNATURE: Clifton L. Mears

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14197 14167

1 M X 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 18 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 805 Thayer Avenue

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Silver Spring
d. STREET ADDRESS: 805 Thayer Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Emma; Middle Irene; Last Osbourn
4. DATE OF DEATH: Month Dec.; Day 12; Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 15, 1881
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Montgomery County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Boswell
14. MOTHER'S MAIDEN NAME: Maria Clarke
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Dr. Raymond A. Osbourn — Address: 8204 Kerry Road Chevy Chase 15, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
420.1
DUE TO (b) Hypertensive heart disease — 15 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a.m. p.m. 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 1946, to Dec 12, 1961, that (I) ~~(we)~~ last saw the deceased alive on Aug. 16 1961, and that death occured at approx. 6:a.m., from the causes and on the date stated above.

22a. SIGNATURE: Michael J. McInerney MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 12, 1961
22c. PHYSICIAN'S NAME (Type): Michael J. McInerney MD
22d. ADDRESS: 1150 Connecticut Avenue, N.W. Washington, D.C. #56

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: Dec 14, 1961
23c. NAME OF CEMETERY OR CREMATORY: MT. OLIVET
23d. LOCATION (City, town or county) (State): WASH. D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: W W Taltarull — ADDRESS: 3603-14th St NW (DC 10)
25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR AIS (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14198

CERTIFICATE OF DEATH

Items 4,21,& 22b, Film G304 1/4/62 iwk 14168

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 52 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park 1671-2
d. STREET ADDRESS: 4214 Guilford Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Suzanne; Middle: (No middle name); Last: Packard
4. DATE OF DEATH: Month: December; Day: 30; Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 1, 1929
9. AGE (In years last birthday): 32 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physical Therapist
10b. KIND OF BUSINESS OR INDUSTRY: (Unemployed)
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Harold E. Bemis
14. MOTHER'S MAIDEN NAME: Hazel Mae Harwood
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): NONE
16. SOCIAL SECURITY NO.: 533-24-7679
17. INFORMANT: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

201X

DUE TO (b) Pseudomonas septicemia — 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c) Hodgkin's Disease — 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from November 8, 1961, to December 30 19 61 that ☒ (we) last saw the deceased alive on December 30 19 61, and that death occured at 10:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward S. Henderson M.D.
22b. DATE SIGNED: January 1, 1962
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Edward S. Henderson, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 1/3/62
23c. NAME OF CEMETERY, OR CREMATORY: FORT LINCOLN CEM
23d. LOCATION (City, town or county) (State): COLMAR MANOR ARCOLA, MD

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS, INC. ADDRESS: SILVER SPRING, MD
25a. REC'D BY REGISTRAR DATE JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Travis

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14199 **CERTIFICATE OF DEATH** 14169

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sumner
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5011 Randall Lane

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sumner 57
d. STREET ADDRESS: 5011 Randall Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LORETTA Middle M Last PALMER
4. DATE OF DEATH: Month Dec. Day 26 Year 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-11-1879
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward L. Mahoney
14. MOTHER'S MAIDEN NAME: ~~P~~ - - Larkin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): - - -
16. SOCIAL SECURITY NO.: - - -
17. INFORMANT: Virginia P. Mather (Daughter) — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary infarction.
DUE TO (b): arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): - Cancer stomach
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 15, 1961 to Dec 26, 1961 that (I) (we) last saw the deceased alive on Dec 24, 1961, and that death occured at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank Finnerty Jr M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Frank A. Finnerty, Jr. M.D.
22d. ADDRESS: 1150 Conn. Ave., N.W. Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12-28-1961
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler Sons Inc.
ADDRESS: Wash. D.C. 1756 Pa. Ave. NW.
25a. REC'D BY REGISTRAR: DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14200 **CERTIFICATE OF DEATH** 14170

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Eventide Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X.3
d. STREET ADDRESS: 2853 Ontario Road N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: SADE Middle: D. Last: BARTRIDGE

4. DATE OF DEATH Month: December Day: 24 Year: 1961

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 7/3/72
9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harrison Dingman
14. MOTHER'S MAIDEN NAME: Sarah Porter Hudson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Lloyd L. Stone — Address: same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 47 1X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
20f. (City or town) (County) (State) —

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Jan 5, 1949, to Dec 24, 1961, that (I) (~~we~~) last saw the deceased alive on Dec 24 1961, and that death occured at 4.45 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas S. Sappington M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 24, 1961
22c. PHYSICIAN'S NAME (Type): Thomas S. Sappington
22d. ADDRESS: 1025 CONNECTICUT AVE. NW

23a. BURIAL, CREMATION, REMOVAL (Specify): cremation
23b. DATE THEREOF: 12/26/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town or county) (State): Prince Georges County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.
ADDRESS: 2901 14th St. N.W. Washington, D.C.
25a. REC'D BY REGISTRAR DATE: DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

Items 18&21 Film 305
1-24-62 ams

1
FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death; any delay is necessary, please execute the certificate, writing the word "pending" in part II in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14201 14171

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1½ mo
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 10007 Belhaven Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Mont
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 45 Bethesda
d. STREET ADDRESS: 10007 Belhaven Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bettye — Middle: Jean — Last: Patterson
4. DATE OF DEATH: Month: Dec — Day: 29 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-24-32
9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse
10b. KIND OF BUSINESS OR INDUSTRY: N.I.H.
11. BIRTHPLACE (State or foreign country): Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: H. M. PATTERSON
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father — Address: H.M. PATTERSON, Jackson, Tenn.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Synergistic poisoning
888.9
DUE TO
(b): Pheno-barbital & ethel alcohol
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-29-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
22b. DATE THEREOF: 12-30-61
22c. NAME OF CEMETERY OR CREMATORY: Hollywood Cemetery
22d. LOCATION (City, town, or country) (State): Jackson, Tenn.

23. FUNERAL DIRECTOR: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR: DATE JAN 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

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FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14172

14202

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 7500 Brookville Rd

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood — 1646-2
d. STREET ADDRESS: 4403 39th St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clifton — Middle: E — Last: Pilcher

4. DATE OF DEATH: Month: Dec — Day: 14 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: Sept. 30, 1911

9. AGE (In years last birthday): 50 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tree Surgeon — Landscaping

10b. KIND OF BUSINESS OR INDUSTRY: Landscaping

11. BIRTHPLACE (State or foreign country): Alberton Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. C.

13. FATHER'S NAME: George H. Pilcher

14. MOTHER'S MAIDEN NAME: ~~Willie~~ Willie Mae Shent ~~[illegible]~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-038205

17. INFORMANT: Charles Pilcher — Address 4403 - 39th St. - Brentwood, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b) Coronary Occlusion — Sudden
DUE TO (c) Ruptured Atheromatous Plaque — unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4-20.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county):
DATE SIGNED: 12-14-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 19, 1961
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Bladensburg, Maryland.

23. FUNERAL DIRECTOR: W. W. CHAMBERS CO.
ADDRESS: 517 11th St. S.E., Wash., D.C.

24a. REC'D BY REGISTRAR DATE: DEC 18 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14203

CERTIFICATE OF DEATH

14173

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 62 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Rockville
d. STREET ADDRESS: 123 W. Middle Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Wickliff — Middle: H — Last: Pollen

4. DATE OF DEATH: Month: Dec. — Day: 14, — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/24/1899
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Green Keeper
10b. KIND OF BUSINESS OR INDUSTRY: Country Club
11. BIRTHPLACE (County & State, or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? USA yes.

13. FATHER'S NAME: Wickliff Pollen
14. MOTHER'S MAIDEN NAME: Annie Reeves

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No.
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-28-6019
17. INFORMANT: Edith Pollen (wife) — Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Ampulla of Vater + Duodenum with generalized metastases.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
155.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1961 to Dec., 1961, that (I) (~~we~~) last saw the deceased alive on 12/13 1961, and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur F. Woodward M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/14/61
22c. PHYSICIAN'S NAME (Type): Arthur F. Woodward
22d. ADDRESS: Rockville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/16/61
23c. NAME OF CEMETERY OR CREMATORY: Frederick Memorial Park
23d. LOCATION (City, town or county) (State): Frederick, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Tyson Wheeler Funeral Home
ADDRESS: 1331 E. Montg. Ave. Rockville, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 18 '61
25b. REGISTRAR'S SIGNATURE: Carter S. Kime

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14204 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 14174

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 10 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 909 Kenbrook Dr

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Silver Spring
d. STREET ADDRESS: 909 Kenbrook Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milton — Middle: Aaron — Last: Pressky

4. DATE OF DEATH: Month: Dec — Day: 23 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-5-1912

9. AGE (In years last birthday): 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Edt. research dir. Wash-Star

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Nath~~ Isadore Pressky

14. MOTHER'S MAIDEN NAME: Fannie Tress

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 198-05-3524

17. INFORMANT: Elaine Pressky (wife) — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
History of CVA Feb 1960

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

EXAMINER'S NAME (Type): FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

DATE SIGNED: 12-23-61

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): BURIAL

22b. DATE THEREOF: DEC. 24, 1961

22c. NAME OF CEMETERY OR CREMATORY: KING DAVID MEM. GARDEN

22d. LOCATION (City, town, or country): FALLS CHURCH (State): VA.

23. FUNERAL DIRECTOR: Dougherty & Sons — ADDRESS: 3501-14 St. N.W.

24a. REC'D BY REGISTRAR — DATE: DEC 28 '61

24b. REGISTRAR'S SIGNATURE: Charles S. Krause

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14205 Items 13 & 23b Film G30h 12/29/61 mh 14175

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 30 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S.Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis 0210-2
d. STREET ADDRESS: 1905 Lincoln Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Brenda; Middle: ; Last: Pugh

4. DATE OF DEATH: Month: December; Day: 20; Year: 1961

5. SEX: Female
6. COLOR OR RACE: Negroid
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: October 12, 1952
9. AGE (In years last birthday): 9 yrs. — IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): - - - -
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Pugh
14. MOTHER'S MAIDEN NAME: Florine Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service): - - - -
16. SOCIAL SECURITY NO.: - - - -
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE EMBOLIZATION
DUE TO (b) SUBACUTE BACTERIAL ENDOCARDITIS
DUE TO (c) MITRAL AND TRICUSPID REGURGITATION

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

41 0 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from Nov. 20, 1961, to Dec. 20, 1961 that I (we) last saw the deceased alive on Dec. 20, 1961 and that death occured at 5:30 AM from the causes and on the date stated above.

22a. SIGNATURE: Bernard H. Feldman M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 20, 1961
22c. PHYSICIAN'S NAME (Type): BERNARD H. FELDMAN LT MC USN
22d. ADDRESS: U. S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 24, 1961
23c. NAME OF CEMETERY OR CREMATORY: Mount Calvery
23d. LOCATION (City, town or county) (State): Arnold, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: William Reese, II
ADDRESS: William Reese Funeral Home, 108 Washington St., Annapolis, Md.
25a. REC'D BY REGISTRAR DATE DEC 26 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

VR A1S (4) 1SM 7/61

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14206 14176

M

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Marilea Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton 16X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

90

3. NAME OF DECEASED (Type or print): First Nannie Middle E. Last Revell
4. DATE OF DEATH: Month December Day 25th Year 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Unknown
9. AGE (In years last birthday): 89 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

I

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Harris
14. MOTHER'S MAIDEN NAME: Minnie Jones
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Brooks Matthews Address: LaPlata, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident 4 days
DUE TO
(b) Cerebral Arteriosclerosis 2 years
DUE TO
(c)

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-2 1961 to 12-25 1961 that (I) (we) last saw the deceased alive on 12-22 1961 and that death occurred at 5:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John Rogers M.D. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-25-61
22c. PHYSICIAN'S NAME (Type): John S. Rogers M.D.
22d. ADDRESS: 112 Shaw Avenue, Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1961
23c. NAME OF CEMETERY OR CREMATORY: St John's
23d. LOCATION (City, town, or county) (State): Clinton, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A Mattingly ADDRESS: 131-11th St SE Wash 3 DC
25a. REC'D BY REGISTRAR DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14207

Reg. Dist. No. 1311

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda Md.

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4532 FAIRFIELD DRIVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 50 Bethesda

d. STREET ADDRESS: 4532 Fairfield Drive

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace Middle: TRUMAN Last: Ridgeway

4. DATE OF DEATH Month: December Day: 13 Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: March 16, 1891

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor - Retired

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otho G. Ridgeway

14. MOTHER'S MAIDEN NAME: Sarah Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Evelyn D. Beall Address: Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute Left Ventricular Heart Failure — 3 hours
DUE TO
(c) Arteriosclerotic Heart Disease — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Non-obstructive Emphysema, Chronic Cor Pulmonale

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 11, 1961, to Dec. 13, 1961, that I last saw the deceased alive on December 13, 1961, and that death occurred at 11:45 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Clifton R. Gruver M.D. ADDRESS (Street, city or town, state): 915 19th St. N.W. Wash. D.C. DATE SIGNED: 12/13/61

PHYSICIAN'S NAME (Type): Clifton R. Gruver, M.D. 915 - 19th St. N.W. Wash. D. C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Dec. 16, 1961

22c. NAME OF CEMETERY ~~OR CREMATORY~~: Frederick

22d. LOCATION (City, town, or county) (State): Warren County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Maddox Funeral Home C.R. Maddox Jr. ADDRESS: Front Royal, Va.

24a. REC'D BY REGISTRAR DATE DEC 18 '61

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 [illegible] be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. [illegible] 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14208 14178

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 25 mins

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE: Maryland b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 48 Chevy Chase

d. STREET ADDRESS: 4730 Bradley Blvd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Martin (ALSO KNOWN AS IRVING SCHACTMAN) Middle: Last: Ross

4. DATE OF DEATH: Month: Dec. Day: 26. Year: 61

5. SEX: Male 6. COLOR OR RACE: White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/9/09

9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: David Ross

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Army

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harriet Hunt - 4904 River Rd., Beth Md. (friend) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Coronary Occlusion, left Circumflex Coronary Artery — "

DUE TO (c) Hemorrhage into Alheioscluotic Plaque — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Brochart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 12-26-61

EXAMINER'S NAME (Type): Frank J. Brochart

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial 22b. DATE THEREOF: 12-28-61 22c. NAME OF CEMETERY OR CREMATORY: Arlington 22d. LOCATION (City, town, or country): Balto (State): Md

23. FUNERAL DIRECTOR: Jack Lewis Inc ADDRESS: 2100 Eutaw Place

24a. REC'D BY REGISTRAR DATE DEC 28 '61 24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14209

Reg. Dist. No. 14179

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 21 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Hospital End Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton
d. STREET ADDRESS: 6006-Belle Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1650-2

75

3. NAME OF DECEASED (Type or print): First: Samuel; Middle: ; Last: Sabato

4. DATE OF DEATH: Month: 12; Day: 21; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒
8. DATE OF BIRTH: October 17, 1899
9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10b. KIND OF BUSINESS OR INDUSTRY: Willard Hotel
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
INFORMANT: Peter Sabato, son — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1 DAY
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSION, ARTERIAL

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from AUG., 1959, to DEC. 21, 1961, that I last saw the deceased alive on DEC. 21, 1961, and that death occurred at 5 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. B. Snow M.D.
ADDRESS (Street, city or town, state): 7950 N.H. Ave. Langley Park, Md.
DATE SIGNED: 12/21/61
PHYSICIAN'S NAME (Type): L. B. SNOW

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/23/61
22c. NAME OF CEMETERY OR CREMATORY: Forest Lawn
22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home, Inc.
ADDRESS: Mt. Rainier, Md.
24a. REC'D BY REGISTRAR DATE: DEC 27 '61
24b. REGISTRAR'S SIGNATURE: Clifton L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14210 Items 2-F1-m G305 - 1/17/62 - iwk 14180

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9200 Wisconsin Ave Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CONGRESSIONAL MANOR

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: 67X-3
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BATHGATE/RFD1 New Jersey
d. STREET ADDRESS: RFD 1 Box 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Katherine Middle: St. Peter Last:
4. DATE OF DEATH: Month 12 Day 10 Year 1961
5. SEX: F
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: March 6 1886
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Patrick Madigan
14. MOTHER'S MAIDEN NAME: Hanora Shanahn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Virginia St Peter Address: 2D SEC Hqt 2nd GSA FT. MEADE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Cerebral arteriosclerosis — 10 min
DUE TO (c)
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Coronary Artery disease, Chronic pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 13 Oct 1958 to 10 Dec 1961 that (I) (we) last saw the deceased alive on 10 Oct 1961, and that death occurred at 8 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David A. Steel M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 10 Dec 1961
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-14-61
23c. NAME OF CEMETERY OR CREMATORY: MARY REST CEMETERY
23d. LOCATION (City, town, or county) (State): DARLINGTON NEW JERSEY

24. FUNERAL DIRECTOR'S SIGNATURE: Deal Funeral Home ADDRESS: 4812 Ft. Lee Rd
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hand

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14211 **CERTIFICATE OF DEATH** 14181

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Virginia~~ VIRGINIA — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington 83X-3
d. STREET ADDRESS: 2347 South Nash St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Prentiss — Middle: Dixon — Last: Sale Sr
4. DATE OF DEATH: Month 12 — Day 27 — Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1892
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Knoxville, Tenn.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Prentiss D. Sale Sr
14. MOTHER'S MAIDEN NAME: Carolyn Hespen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were dates of service): no
16. SOCIAL SECURITY NO.: ?
17. INFORMANT — Address: Home Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b): hypertension
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

33 IX

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 19, 1961, to Dec 27, 1961, that (I) (we) last saw the deceased alive on Dec 27 1961, and that death occured at 11 AM, from the causes and on the date stated above.

22a. SIGNATURE: Belden R. Reap MD M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): BELDEN R. REAP, M.D.
22d. ADDRESS: 11502 GRANDVIEW AVE, WHEATON, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE THEREOF: 12/30/61
23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery
23d. LOCATION (City, town or county) (State): Washington, D.C.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR: DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14212 **CERTIFICATE OF DEATH** 14182

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 6304 TONE DR.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: MD. b. COUNTY: MONT.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA 59
d. STREET ADDRESS: 6304 TONE DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: HYMAN Middle: Last: SALZBERG
4. DATE OF DEATH: Month: 12 Day: 10 Year: 19 61
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: APR 15 1893
9. AGE (In years last birthday): 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: TRUCKING
11. BIRTHPLACE (County & State, or foreign country): POLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ABRAHAM SALZBERG
14. MOTHER'S MAIDEN NAME: YETTA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown): NO (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 060-20-4414
17. INFORMANT: SAMUEL SALZBERG Address: 8409 SPENCER ST. CHEVY CHASE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
(a) HEPATIC METASTASES — INTERVAL BETWEEN ONSET AND DEATH: 9 MOS
153.8 DUE TO
(b) CARCINOMA OF THE COLON — 17 MOS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from NOV 7, 19 61, to DEC. 10, 19 61, that (I) (~~we~~) last saw the deceased alive on 12/10 19 61, and that death occured at 1:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: J.H. Tuohy M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/10/61
22c. PHYSICIAN'S NAME (Type): J.H. TUOHY, M.D.
22d. ADDRESS: 7720 WISCONSIN AVE BETHESDA 14, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12-10-61
23c. NAME OF CEMETERY OR CREMATORY: MT. HEBRON
23d. LOCATION (City, town or county) (State): LONG ISLAND, N.Y.

24 FUNERAL DIRECTOR'S SIGNATURE: GOLDBERG FUNERAL HOME ADDRESS: 4217 9TH ST. NW
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4) 15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14213

CERTIFICATE OF DEATH

Item 23b, Film G304 1/2/62 iwk

14183

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 42 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): La Jolla
d. STREET ADDRESS: PO Box 447
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

43x3

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Roosa; Last: Sanderson

4. DATE OF DEATH: Month: December; Day: 22; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-25-82

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Military

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Sanderson

14. MOTHER'S MAIDEN NAME: Alice Oulahan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: WIFE: Florence S. Sanderson, Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PERIPHERAL VASCULAR Collapse
DUE TO
(b) Thrombosis in distribution Left Middle Cerebral Artery
DUE TO
(c) ARTERIOSCLEROSIS, GENERALIZED.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 2 November, 1961 to 22 December, 1961, that ☒ (we) last saw the deceased alive on 22 December 1961, and that death occured at 18:56 PM from the causes and on the date stated above.

22a. SIGNATURE: John R Warmolts MD M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: Dec 23, 1961

22c. PHYSICIAN'S NAME (Type): U. R. WARMOLTS, LT MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Dec. 26, 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Vir.

24 FUNERAL DIRECTOR'S SIGNATURE: R. E. Burnett, Jr. ADDRESS: Wisconsin Ave., Bethesda, Md.

25a. REC'D BY REGISTRAR DATE: DEC 27 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14214 14184

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible]pletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon [illegible]papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10709 Glenwild Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ida Middle: E. Last: Sarra
4. DATE OF DEATH: Month: Dec Day: 12 Year: 1961
5. SEX: Feamle
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/15/79
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Gaertner
14. MOTHER'S MAIDEN NAME: Johanna Frasius
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give were or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. Alvin Sarra, son Address: same as above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Paralytic Ilius — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
572.1
DUE TO (b) Diverticulitis with perforation and abscess formation & Ascites — 2 weeks
~~DUE TO~~ (c) Nephrosclerosis with uremia — Undetermined
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic-Myocarditis with decompensation.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 16, 1961, to Dec. 12, 1961, that (I) (we) last saw the deceased alive on Dec 11, 1961, and that death occured at 3:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: George L. Ball M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/12/61
22c. PHYSICIAN'S NAME (Type): George L. Ball
22d. ADDRESS: 10620 GA. AVE. SIL. SP. MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 15, 1961
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince George County, Md
24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14215

CERTIFICATE OF DEATH

14185

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Carroll Hall Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE:
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS: 2737 Devonshire Pl. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Wilson — Middle: — Last: Satterfield

4. DATE OF DEATH: Month: Dec. — Day: 28 — Year: 1961

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/25/08
9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Piano Tuner
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (County & State, or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawrence Satterfield
14. MOTHER'S MAIDEN NAME: Kathryn Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give wer or dates of service):
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Helen S. Steeds — Address: 505 S. Genesee Ave. Los Angeles 36, Calif.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
600.0
DUE TO (b): Pyelonephritis
DUE TO (c): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old cerebral vascular episode

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): None
20c. TIME OF INJURY: Month, Day, Year: None 19 — Hour a.m. p.m.
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/26, 1961, to Present, 19..., that (I) (we) last saw the deceased alive on 12/28 19 61, and that death occured at 6:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John B. Umhau M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/28/61
22c. PHYSICIAN'S NAME (Type): John B. Umhau
22d. ADDRESS: 8805 Conn. Ave Ch. Ch. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): cremation
23b. DATE THEREOF: 12/29/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Crematory
23d. LOCATION (City, town or county) (State): Prince Georges, County, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. — ADDRESS: 2901 14th St. N.W. Washington 9, D.C.
25a. REC'D BY REGISTRAR — DATE: JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Clifford S. Hines

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14216 **CERTIFICATE OF DEATH** 14186

Items 8,9 & 14 Film G306 2/1/62 lwk

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

c. LENGTH OF STAY IN 1b: 10 YRS.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ------

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md. 22

d. STREET ADDRESS: 9004 Sudbury Road 1

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK Middle R Last SAUNDERS

4. DATE OF DEATH Month Dec. Day 7, Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 18, 1883 ~~JULY 4, 1886~~

9. AGE (In years last birthday): ~~72~~ 78 yrs. IF UNDER 1 YEAR: Months 5 Days 3 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): NORFOLK, VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: WILLIAM T. SAUNDERS

14. MOTHER'S MAIDEN NAME: ROSELLE ~~WINNIGER~~ Winingder

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 224-26-1139

17. INFORMANT: MISS EDITH SAUNDERS, Address: SAME AS 2D, DAUGHTER

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adenocarcinoma left upper lung — 18 months

163X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 1948, 19 61, to Dec 7, 19 61 that (I) (~~we~~) last saw the deceased alive on Dec 7 19 61 and that death occurred at 10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Saul Holtzman M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Saul Holtzman

22d. ADDRESS: 1800 E St. NW Wash. DC

23a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

23b. DATE THEREOF: 12/8/61

23c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CREMATORY

23d. LOCATION (City, town, or county) (State): BLADENSBURG, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Joseph Bowlers Sons ADDRESS: 1756 Pa Ave NW

25a. REC'D BY REGISTRAR DATE DEC 11 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14217 **CERTIFICATE OF DEATH** 14187

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 60 Bethesda
d. STREET ADDRESS: 8001 Bradley Blvd. ~~Old Georgetown Rd.~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: R. — Last: Scanlan

4. DATE OF DEATH: Month: 12 — Day: 27 — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 16, 1899
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Industrial Engineer
10b. KIND OF BUSINESS OR INDUSTRY: ~~Ind~~ Engineer
11. BIRTHPLACE (County & State, or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ~~Arthur~~ Andrew L.
14. MOTHER'S MAIDEN NAME: Harriett Lingo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give year or dates of service): no
16. SOCIAL SECURITY NO.: 579-03-1601
17. INFORMANT: Dorothy - wife — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: 2 months
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Phlebitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/1/ 1961 to 12/27 1961, that (I) (we) last saw the deceased alive on 12/27/61 19, and that death occured at 10:30 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Dr Joseph Kenrick M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/28/61
22c. PHYSICIAN'S NAME (Type): Dr JOSEPH KENRICK
22d. ADDRESS: 6450 Wisconsin Ave, Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 1/2/62
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR — DATE: JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Indiana S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14218

CERTIFICATE OF DEATH

14188

1. PLACE OF DEATH
a. COUNTY: ~~Maryland~~ Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: two weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1701 Pricilla Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

M 75 1 0 1

3. NAME OF DECEASED (Type or print): First: Louis — Middle: Brooks — Last: Schneider

4. DATE OF DEATH: Month: December — Day: 17 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: October 25 1883

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder - retired

10b. KIND OF BUSINESS OR INDUSTRY: Own business

11. BIRTHPLACE (County & State, or foreign country): Washington D.C.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis H. Schneider

14. MOTHER'S MAIDEN NAME: Adele Brooks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Flourney C. Schneider — Address: 1353 Iris Street, N.W. Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): THROMBOSIS L. MIDDLE CEREBRAL ARTERY — INTERVAL BETWEEN ONSET AND DEATH: 10 DAYS
410X
DUE TO (b): CONGESTIVE HEART FAILURE — 2 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): MITRAL INSUFFICIENCY — 10 YRS.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-5 19 59 to 12-17 19 61, that (I) (we) last saw the deceased alive on 12-17 19 61, and that death occured at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L B Snow M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/17/61

22c. PHYSICIAN'S NAME (Type): LEE B. SNOW

22d. ADDRESS: 7950 NEW HAMPSHIRE AVE, LANGLEY PARK, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 12/20/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington Memorial Cemetery

23d. LOCATION (City, town or county) (State): Arlington, New Jersey

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Pirka — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 22 '61

25b. REGISTRAR'S SIGNATURE: Lillian S. Timms

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14219 — 14189

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 14 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Leamor Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C. 47X-3
d. STREET ADDRESS: 2511 Lee St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Leona — Middle: Elizabeth — Last: Schoyer
4. DATE OF DEATH: Month: 12 — Day: 24 — Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-7-1891
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt. Ret.
11. BIRTHPLACE (County & State, or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: Louis Schoyer
14. MOTHER'S MAIDEN NAME: Leona Beavers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of the Ovary with
DUE TO (b): intradermal metastasis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: six months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): None.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/13, 1961, to 12/24, 1961, that (I) (we) last saw the deceased alive on 12/23 1961, and that death occured at 7:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Michael R. Dobridge M.D. — M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/24/61
22c. PHYSICIAN'S NAME (Type): Michael R. Dobridge
22d. ADDRESS: 10620 Georgia Ave Silver Spring Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/27/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemt.
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph F. Birch's Sons — ADDRESS: Washington, D. C.
25a. REC'D BY REGISTRAR: DATE DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14220 14190

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): West Hyattsville 1655-2
d. STREET ADDRESS: 1610 Erskine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joan; Middle: Dawn; Last: Schuster
4. DATE OF DEATH: Month: December; Day: 30; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 17, 1939
9. AGE (In years last birthday): 22 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist
10b. KIND OF BUSINESS OR INDUSTRY: Government Agency
11. BIRTHPLACE (County & State, or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Francis X. Schuster
14. MOTHER'S MAIDEN NAME: Margaret Uzonyl
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 579-52-3420
17. INFORMANT: The Medical Record, The Clinical Center, Bethesda 14, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: — INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Congestive Failure and Acute Pulmonary Edema — 1 day
456X
DUE TO (b) Right lower lobe pneumonia and bleeding from GI tract. — 4 days
DUE TO (c) Disseminated lupus Erythematosus — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from December 27, 1961 to December 30 1961, that I (we) last saw the deceased alive on December 30 19 61, and that death occured 8:00PM, from the causes and on the date stated above.

22a. SIGNATURE: Mark W Bitensky M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 30, 1961
22c. PHYSICIAN'S NAME (Type): Mark W. Bitensky, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JAN 3 1962
23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L CEM.
23d. LOCATION (City, town or county) (State): ARLINGTON, VA.

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: 254 Burrell St. NW WASH D.C.
25a. REC'D BY REGISTRAR: DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
[illegible]NERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible]pletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14221 14191

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Allegheny
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pittsburgh 75X-3
d. STREET ADDRESS: 5300 Orchard Hill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jean; Middle: Paulette; Last: Schwartz

4. DATE OF DEATH: Month: December; Day: 13; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: May 11, 1943
9. AGE (In years last birthday): 18 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul Schwartz
14. MOTHER'S MAIDEN NAME: Regina Conway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Unascertainable
17. INFORMANT: The Medical Records — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 minute
754.5
DUE TO
(b): Mitral Valve Insuffiency — 18 years
DUE TO
(c): Congenital Heart Lesions — 18 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from December 10, 19 61 to December 13, 61, that I (we) last saw the deceased alive on December 10, 19 61, and that death occured at 4:55 PM from the causes and on the date stated above.

22a. SIGNATURE: Kenneth L. Melman M.D.
22b. DATE SIGNED: December 14, 1961
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Kenneth L. Melman, M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit 12/16/61
23b. DATE THEREOF:
23c. NAME OF CEMETERY OR CREMATORY: Allegheny County
23d. LOCATION (City, town or county) (State): Pittsburgh, Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 21 61
25b. REGISTRAR'S SIGNATURE: Anthony L. Manna

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14222 14192

1 (M)

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 30 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

50

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Georgia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Claxton 49 X 3
d. STREET ADDRESS: P.O. Box 426
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Susan; Middle: None; Last: Scott

4. DATE OF DEATH: Month: December; Day: 6; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 21, 1956
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawton D. Scott
14. MOTHER'S MAIDEN NAME: Loretta Barrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Address: The Medical Records, The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

204.3

DUE TO (b) Septicemia, probably staphylocci — 18 hours

DUE TO (c) Acute lymphoctic leukemia — 15 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

2Dd. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from November 6, 1961, to December 6, 19 61 that (I) (we) last saw the deceased alive on December 6, 19 61, and that death occured at 1:55 PM from the causes and on the date stated above.

22a. SIGNATURE: Thorne S. Winter, III M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 12/6/61

22c. PHYSICIAN'S NAME (Type): Thorne S. Winter, III, M.D.

22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: Brewton Cemetery
23d. LOCATION (City, town or county) (State): Evans Co. Georgia

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: DEC 8 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14223

Reg. Dist. No. 14193

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY 6416 Tindale Terrace Beth. Md
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 Montgomery County
d. STREET ADDRESS 6416 Tindale Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Mary Middle Seeback Last
4. DATE OF DEATH Month 12 Day 10 Year 1961
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-26-61
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR Months 3 Days 14 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Harry P. Seeback
14. MOTHER'S MAIDEN NAME Jean E. Cissel
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Harry P. Seeback Address 2 D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition

757.3

DUE TO (b) Congenital Heart - Cerebral Palsy Birth

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Hydronephrotic Kidney - Glaucoma Birth

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-26, 1961, to 12-10, 1961, that I last saw the deceased alive on 12-10, 1961, and that death occurred at 9:10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert D. Cawley M.D. ADDRESS (Street, city or town, state) 5506 Connecticut N.W. Wash D.C. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/13/61
22c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery
22d. LOCATION (City, town, or county) Arlington (State) Va.

23. FUNERAL DIRECTOR'S SIGNATURE Timothy Hanlon ADDRESS 4748 Wisc. Ave.
24a. REC'D BY REGISTRAR DATE DEC 14 '61
24b. REGISTRAR'S SIGNATURE Collins S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled in by the funeral director or the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9VVVVVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14224 **CERTIFICATE OF DEATH** 14194

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Mont.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase.
d. STREET ADDRESS: 5404 Western Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RUTH Middle: E. BOND Last: SHOEMAKER
4. DATE OF DEATH: Month 12 Day 11 Year 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/12/88.
9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Piano teacher.
10b. KIND OF BUSINESS OR INDUSTRY: Self employed
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel Bond
14. MOTHER'S MAIDEN NAME: Hattie Hadaway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.: 578-48-2722
17. INFORMANT: Donald Shoemaker Address: 4707 Wyandanch Rd. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — 3 mo.
DUE TO (b): Arteriosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus duodenal ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 9/29, 1961, to 12/11, 1961, that (I) ~~(we)~~ last saw the deceased alive on 12/11 1961, and that death occured at 7:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: I. L. Marks M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-11-61
22c. PHYSICIAN'S NAME (Type): I. L. MARKS, M.D.
22d. ADDRESS: 6306 Wisconsin Ave, Ch. Ch. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/14/61
23c. NAME OF CEMETERY OR CREMATORY: Elderbrook Church Cem.
23d. LOCATION (City, town or county) (State): Washington, D. C.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 15 61
25b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours, after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14225 — 14195

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Resmor Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): 06 Rockville
d. STREET ADDRESS: 12200 Stoney Creek Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katharine — Middle: Danforth — Last: Shriver

4. DATE OF DEATH: Month: December — Day: 26 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 6/2/1879
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months: 6 Days: 24 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: (Unknown) Danforth
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give were or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Louise S. Douglass-Daughter-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hr
DUE TO (b): Bronchopneumonia — 2 w
DUE TO (c): old Cerebrovascular accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis Aortic
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov, 1961, to Dec 26, 1961, that (I) (we) last saw the deceased alive on Dec 26 1961, and that death occured at 15:20 PM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): W. H Killay
22d. ADDRESS: 8218 Wisconsin Ave Bethesda Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-28-61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Prince George Co., Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR — DATE: JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VR A15 (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14226

CERTIFICATE OF DEATH

14196

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (rural)
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manassas 83x·3
d. STREET ADDRESS: 109 Perce St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rochelle — Middle: Marie — Last: Simond

4. DATE OF DEATH: Month: December — Day: 26 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 23, 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months: 6, Days: 3 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roger Comile Simond

14. MOTHER'S MAIDEN NAME: Ofelina Hernandez

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give year or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father Roger Comile Simond — Address: Same as 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leukemia, Acute Lymphoblastic
204.3
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that ☒ (this hospital) attended the deceased from Dec 26, 1961 to Dec 26, 1961, that ☒ (we) last saw the deceased alive on Dec 26 19 61, and that death occured at 10:55 AM the causes and on the date stated above.

22a. SIGNATURE: L.P. Scott M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 12-27-61

22c. PHYSICIAN'S NAME (Type): L.P. SCOTT, LCDR MC USN

22d. ADDRESS: U.S. Naval Hospital, Bethesda, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 30 Dec 1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Baker & Son Funeral Home — ADDRESS: Baker and Son Funeral Home, Manassas, Virginia

25e. REC'D BY REGISTRAR — DATE: DEC 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Keene

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

Montgomery Virginia

Bethesda (rural) 1 day Manassas

U.S. Naval Hospital 109 Pere St. x

Rochelle Marie Simond December 26 61

x

Female Case June 23, 1961 6 3

Virginia USA

Roger Comlie Simond Orfelia Hernandez

Father Roger Comlie Simond Same as 2

x Dec 26 61 Dec 26 61 Dec 26 61 x

Dec 26 61 10:55 PM

x 12-27-61

E.P. SCOTT, LCDR MC USN U.S. Naval Hospital, Bethesda, Maryland

Burial 30 Dec 1961 Arlington National Arlington, Virginia

Baker and Son Funeral Home, Manassas, Virginia

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14227 14197

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: West Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Romney 85 X 3
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jennifer; Middle: Ann; Last: Solan

4. DATE OF DEATH: Month: December; Day: ; Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1 October 1961
9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months 2, Days 27 IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George M. Solan
14. MOTHER'S MAIDEN NAME: Marjorie Sonnenann

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Record, Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months
754.5
DUE TO (b) Congenital Heart Disease (Tricuspid atresia) — 2 mo. 27 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 20, 1961 to December 28 1961, that (I) (we) last saw the deceased alive on December 28 1961, and that death occured at 10:20 AM, from the causes and on the date stated above.

22a. SIGNATURE: Richard P. Anderson M.D.
22b. DATE SIGNED: December 28, 1961
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. PHYSICIAN'S NAME (Type): Richard P. Anderson
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit
23b. DATE THEREOF: 12-28-61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Moorefield, W. Va.

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
25a. REC'D BY REGISTRAR DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 M 50 I 2 1

9 VVV VVV XVI

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14228 **CERTIFICATE OF DEATH** 14198

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 27 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. 47X-3
d. STREET ADDRESS: 6151 31st N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret Middle: B Last: Somervell
4. DATE OF DEATH: Month: Dec Day: 16 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-14-10
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Bogley, Harting
11. BIRTHPLACE (County & State, or foreign country): — —
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: A. Harry Borjes
14. MOTHER'S MAIDEN NAME: Tebbits Cardwell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Sons — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma of the cervical — INTERVAL BETWEEN ONSET AND DEATH: 2½ yr.
DUE TO (b): glands of the right side of neck
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 198.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June 1955 to Dec 1961, that (I) (~~was~~) last saw the deceased alive on 16 Dec 1961 and that death occured at 9:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Herbert Martyn Jr M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 16 Dec 61
22c. PHYSICIAN'S NAME (Type): HERBERT MARTYN JR
22d. ADDRESS: 5029 Bethesda Ave, Beth. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12-19-1961
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland, Md.
24 FUNERAL DIRECTOR'S SIGNATURE: Joseph Gawler Sons ADDRESS: 1756 Pennsylvania Ave. Wash. D.C.
25a. REC'D BY REGISTRAR DATE: DEC 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

HERBERT MARTYN JR 5-21 Rettinger Ave Balti Md

Cremation 12-12-1961 Cedar Hill Crematory Suitland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14229 14199

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X3
d. STREET ADDRESS: 5307 42nd. St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ada Middle: B Last: Spence
4. DATE OF DEATH: Month: December Day: 22, Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2/27/76
9. AGE (In years last birthday): 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: John Henry Spence
14. MOTHER'S MAIDEN NAME: Sarah Jane Stone
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Neice, Theresa Spence, same as above Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial decompensation with Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO (b) Myocardial degeneration, chronic — One year
DUE TO (c) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Padgett's disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 1948 to Dec. 22, 1961, that (I) (~~we~~) last saw the deceased alive on December 21 1961, and that death occured at 9:40 AM, from the causes and on the date stated above.

22a. SIGNATURE: Stewart Clapp M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12.22.61
22c. PHYSICIAN'S NAME (Type): Stewart Clapp
22d. ADDRESS: 4740 Chevy Chase Av. Ch. Ch. 15 Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/26/61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.
23d. LOCATION (City, town or county) (State): Washington DC

24 FUNERAL DIRECTOR'S SIGNATURE: Chevy Chase Funeral Home ADDRESS: 5103 Wis. Ave N.W.
25a. REC'D BY REGISTRAR DATE: DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after ... Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14230 — 14200

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 5035 Bradley Boulevard
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: E. — Last: Stanford II

4. DATE OF DEATH: Month: Dec. — Day: 26 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 7 1961

9. AGE (In years last birthday): IF UNDER 1 YEAR: Months 5, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wash. D.C

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: RussellE Stanford

14. MOTHER'S MAIDEN NAME: Donna Covey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Russell E. Stanford-father-same 2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral contusions and lacerations — INTERVAL BETWEEN ONSET AND DEATH: sudden
825 X
DUE TO (b): Fracture skull — "
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Automobile accident — "

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Passenger in car involved in accident

20c. TIME OF INJURY Hour a.m.: 5:52 p.m. — Month, Day, Year: 12-26 1961

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town): Bethesda — (County): Montg — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12-26-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/29/61
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or country) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE JAN 2 '62
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14231

CERTIFICATE OF DEATH

14201

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 13½ days

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier 1646.2
d. STREET ADDRESS: 3370 Chillum Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium and Hospital

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: (NMN); Last: Startari

4. DATE OF DEATH: Month: December; Day: 24; Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: April 17 1894
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Newstand) Operator
10b. KIND OF BUSINESS OR INDUSTRY: Newstand
11. BIRTHPLACE (County & State, or foreign country): Italy
12. CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Vitale Startari
14. MOTHER'S MAIDEN NAME: Florence Bacqua

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PNEUMONIA WITH PULMONARY CONGESTION AND EDEMA — INTERVAL BETWEEN ONSET AND DEATH: several days

493X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): POST OPERATIVE STATUS FROM CARCINOMA OF THE BLADDER 12 days

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Arthur J. Willets M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 24-1961
22c. PHYSICIAN'S NAME (Type): —
22d. ADDRESS: —

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec 27, 1961
23c. NAME OF CEMETERY OR CREMATORY: George Washington
23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: F. Gasch's Sons Hyattsville Md.
25a. REC'D BY REGISTRAR DATE: JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Carlton L. Krause

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 FOR STATE HEALTH DEPT.

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DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14232

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11202

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Wash San + Hosp.

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 27 Silver Spring
d. STREET ADDRESS: 1902 Rosemary Hills Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Pearl Middle: G. Last: Stewart
4. DATE OF DEATH: Month: Dec. Day: 18 Year: 1961
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-15-82
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES Selby
14. MOTHER'S MAIDEN NAME: Alverda McKnew
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mr Charles W Stewart - Son Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. BROSCHART
Address (Street, city, town, or county)
DATE SIGNED: 12-18-61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/21/61
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or country) (State): Washington D.C.

23. FUNERAL DIRECTOR: Raymond A Zisker ADDRESS: 8434 Georgia Avenue Silver Spring, Maryland
Warner E. Pumphrey, Inc.
24a. REC'D BY REGISTRAR DATE: DEC 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1 X2

FOR STATE HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14233 14203

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): SUBURBAN

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MANCHESTER 06 X-2
d. STREET ADDRESS: RT#1
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Lionel Middle: L. EDWARD Last: STICKLES

4. DATE OF DEATH: Month: DEC. Day: 13 Year: 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 9-13-1901
9. AGE (In years last birthday): 60 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forman
10b. KIND OF BUSINESS OR INDUSTRY: Ridgely Const. Co.
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Henry B. Stickles
14. MOTHER'S MAIDEN NAME: Sarah Furr

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): unknown (If yes give war or dates of service): unknown
16. SOCIAL SECURITY NO.: 202-18-6909
17. INFORMANT: Address: Lionel E. Stickles Jr. Manchester Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thoracic hemorrhage
912.3
DUE TO
(b): rupture of heart
DUE TO
(c): struck by crane

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Struck by crane
20c. TIME OF INJURY Hour a.m. p.m. 8:25 Month, Day, Year 12-13 1961
20d. INJURY OCCURRED While at work [X] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Construction Job
20f. (City or town): Bethesda (County): Monty (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Frank J. Brochart M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 12-13-61
EXAMINER'S NAME (Type): Frank J. Brochart
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12-16-61
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
22d. LOCATION (City, town, or country): Towson (State): Maryland

23. FUNERAL DIRECTOR: Brooks Funeral Service
ADDRESS: Towson Maryland

24a. REC'D BY REGISTRAR DATE: DEC 15 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Hirsch

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14234 14204

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 39 Silver Spring
d. STREET ADDRESS: 10810 - Keller St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Beulah Middle: Lee Last: Swadley

4. DATE OF DEATH: Month: Dec. Day: 21 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/14/09
9. AGE (In years last birthday): 52 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Maker
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Truman Kiser
14. MOTHER'S MAIDEN NAME: Sarah Virginia Reprode
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Carl Swadley Address: Same As Above.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Rectum — INTERVAL BETWEEN ONSET AND DEATH
154X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec. 1960 to Dec. 21, 1961 that (I) (we) last saw the deceased alive on Dec. 21 1961, and that death occured at 4:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Belden R. Reap M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec. 22, 1961
22c. PHYSICIAN'S NAME (Type): BELDEN R. REAP, M.D.
22d. ADDRESS: WHEATON, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-trans
23b. DATE THEREOF: 12/22/1961
23c. NAME OF CEMETERY OR CREMATORY: Sugar Grove Cemetery
23d. LOCATION (City, town or county) (State): Sugar Grove, West Virginia

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14235

CERTIFICATE OF DEATH

1. PLACE OF DEATH
e. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 20 minutes 60
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 8820 - River Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Infant Girl; Middle: ; Last: Swain

4. DATE OF DEATH: Month: Dec.; Day: 10; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐
8. DATE OF BIRTH: 12/10/61
9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min. 20 min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Freemont Swain
14. MOTHER'S MAIDEN NAME: Nancy Ann Cunningham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother's chart — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ANOXIA — INTERVAL BETWEEN ONSET AND DEATH: 20 MIN
DUE TO (b): HYDROCEPHALUS — DEVELOPMENTAL
DUE TO (c): CONGENITAL MALFORMATION — DEVELOPMENTAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 752X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): SPINAL MENINGOCELE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/10, 1961 to 12/10, 1961, that (I) (we) last saw the deceased alive on 12/10 1961, and that death occured at 6:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Charles Savarese M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/11/61
22c. PHYSICIAN'S NAME (Type): CHARLES J. SAVARESE MD
22d. ADDRESS: 4890 BATTERY LANE BETHESDA MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/12/61
23c. NAME OF CEMETERY OR CREMATORY: Gate of Heaven Cem.
23d. LOCATION (City, town or county) (State): Silver Spring, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey, Bethesda, Maryland
ADDRESS:
25a. REC'D BY REGISTRAR DATE: DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Hume

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14236 14206

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 21 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: West Virginia
b. COUNTY: ✓
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Charleston 85x-3
d. STREET ADDRESS: 1552 Bridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frederica; Middle: (None); Last: Talbot

4. DATE OF DEATH: Month: December; Day: 25; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 25, 1904
9. AGE (In years last birthday): 57 yrs. IF UNDER 1 YEAR: Months: 8; Days: 0; IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Church
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Dalzell
14. MOTHER'S MAIDEN NAME: Mary Peyton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: Unavailable
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hours
DUE TO
(b) Pyelonephritis — ---
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
a) Metastatic Breast Carcinoma
b) Status post-hypophysectomy
c) Bone marrow depression secondary to chemotherapy.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from December 4, 1961, to December 25 19 61 that I (we) last saw the deceased alive on December 25, 19 61, and that death occured at 6:45 AM, from the causes and on the date stated above.

22a. SIGNATURE: Michael Field M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 26, 1961
22c. PHYSICIAN'S NAME (Type): Michael Field, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1961
23c. NAME OF CEMETERY OR CREMATORY: St. Matthews,
23d. LOCATION (City, town or county) (State): Charleston, West Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14237 **CERTIFICATE OF DEATH** 14207

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10815 Madison Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 36 Kensington
d. STREET ADDRESS: 10815 Madison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank; Middle: Jordan; Last: Taylor
4. DATE OF DEATH: Month: December; Day: 7; Year: 1961
5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 27, 1896
9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architect
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Frank C. Taylor
14. MOTHER'S MAIDEN NAME: Anna B. Fisher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Margarett Taylor-Wife-same 2d — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr
420.0
DUE TO
(b) Arteriosclerotic Heart Disease — Unknown
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m. 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from May 1954, to 12-7 1961 that (I) (we) last saw the deceased alive on 12-7 1961, and that death occurred at 7:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: George Sharpe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-8-61
22c. PHYSICIAN'S NAME (Type): George Sharpe M.D.
22d. ADDRESS: 10511 Summit Ave. Kensington Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/11/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town, or county) (State): Arlington, Virginia
24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 11 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4) 1SM 9/59

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14238

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14208

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence prior to admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X3
d. STREET ADDRESS: 4057 Grant St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: Woodson — Last: Terrell

4. DATE OF DEATH: Month: 12 — Day: 8 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 2/26/15

9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charley Terrell

14. MOTHER'S MAIDEN NAME: Cornelia Duke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): No

16. SOCIAL SECURITY NO.: Not stated

17. INFORMANT — Address: Grace Terrell - 4067 Grant St. NE. (wife

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes
825X
DUE TO (b) Rupture of liver (marked)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Contused chest (st)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Driver of car involved in accident.

20c. TIME OF INJURY: Hour a.m. p.m. 12:05am — Month, Day, Year: 12/8/61 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Silver Spring, Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 12/8/61

22a. BURIAL, CREMATION, REMOVAL (Specify): 12-12-61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or country) (State): Virginia

23. FUNERAL DIRECTOR — ADDRESS: Frazier's Funeral Home, 384-Rd. Ave. N.W. DC

24a. REC'D BY REGISTRAR DATE: DEC 12 61

24b. REGISTRAR'S SIGNATURE: [illegible]

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14239 **CERTIFICATE OF DEATH** 14209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sandy Spring
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Frederic; Middle L.; Last Thomas

4. DATE OF DEATH: Month December; Day 31; Year 19 61

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 29, 1879
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker
10b. KIND OF BUSINESS OR INDUSTRY: Banking
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Alban Thomas
14. MOTHER'S MAIDEN NAME: Sue Leggett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): unknown
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 wks.
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Nov, 1959, to Dec, 1961, that (I) (we) last saw the deceased alive on Dec 31 1961, and that death occured at 5:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: A. D. Bonifant M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): A. D. BONIFANT
22d. ADDRESS: Sandy Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 3, 1962
23c. NAME OF CEMETERY OR CREMATORY: Friends Cemetery
23d. LOCATION (City, town or county) (State): Sandy Spring, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber
ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR DATE JAN 4 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

M

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14240

CERTIFICATE OF DEATH

14211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
1SM 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 20 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 116 Park Ave.
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maude — Middle: Elizabeth — Last: Thompson

4. DATE OF DEATH: Month: 12 — Day: 31 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH: 7-27-07
9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Walter Gregg
14. MOTHER'S MAIDEN NAME: Cora Norris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp. Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 12/30/61
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1/24/ 1955, to Dec. 31, 1961, that (I) (we) last saw the deceased alive on Dec. 31 1961, and that death occured at 8.P. M, from the causes and on the date stated above.

22a. SIGNATURE: Howard T. Morse M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/31/61
22c. PHYSICIAN'S NAME (Type): Howard T. Morse
22d. ADDRESS: 7030 Carroll Ave Takoma Park Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JAN. 4, 1962
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county): Washington (State): D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters — ADDRESS: 254 Carroll St. N.W. Wash. D.C.
25a. REC'D BY REGISTRAR: DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14241 **CERTIFICATE OF DEATH** 14210

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5da 15 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington Sanitarium and Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Takoma~~ Silver Spring 24
d. STREET ADDRESS: 733 Sligo Avenue, Apt. 615 ~~1213 Eastern Park Drive~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: Deane — Last: Thomson
4. DATE OF DEATH: Month: December — Day: 2 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: November 13, 1880
9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (RET.) ~~Housewife~~ CLERK-TYPIST
10b. KIND OF BUSINESS OR INDUSTRY: Post Office Dept
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Belford
14. MOTHER'S MAIDEN NAME: Anna Heffelfinger
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): ———
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Record. — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: -15 MO.
153.1
DUE TO (b) PRIMARY ADENOCARCINOMA, TRANSVERSE COLON — 15 MO.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Oct., 1958 to 2 Dec., 1961, that (I) (we) last saw the deceased alive on 2 Dec. 1961, and that death occured at 11:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Seruch T. Kimble M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): SERUCH T. KIMBLE
22d. ADDRESS: 927 Pershing Dr., Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/5/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Montgomery Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska — ADDRESS: 8434 Georgia Avenue
WARNER E. PUMPHREY, INC. Silver Spring, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 5 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14242 14212

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 111 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shamokin
d. STREET ADDRESS: 142 South Franklin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

75X·3

3. NAME OF DECEASED (Type or print): First: Stephen Middle: Lawrence Last: Tighe
4. DATE OF DEATH: Month: December Day: 25, Year: 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 2, 1910
9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months 4 Days 23 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shipper and Checker
10b. KIND OF BUSINESS OR INDUSTRY: Dressed Beef Co.
11. BIRTHPLACE (County & State, or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John J. Tighe
14. MOTHER'S MAIDEN NAME: Mary Martin
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 178-05-1463
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Thyroid gland metastatic to lungs, liver — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
(b) Congestive heart failure of unknown etiology — 4 months
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

194X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from September 5, 1961 to December 25, 1961 that (I) (we) last saw the deceased alive on December 25, 1961, and that death occured at 4:00AM from the causes and on the date stated above.

22a. SIGNATURE: Carl J Bentzel M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: December 26, 1961
22c. PHYSICIAN'S NAME (Type): Carl J. Bentzel, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/29/1961
23c. NAME OF CEMETERY OR CREMATORY: St. Mary's
23d. LOCATION (City, town or county) (State): Coal Township Penna.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 28 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14243 14213

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 40 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Nebraska
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Papillion
d. STREET ADDRESS: 310 Crest Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

64X·3

50

3. NAME OF DECEASED (Type or print): First Michael, Middle Laverne, Last Timmerman
4. DATE OF DEATH: Month December, Day 2, Year 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 23, 1954
9. AGE (In years last birthday): 7 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Laverne Timmerman
14. MOTHER'S MAIDEN NAME: Patricia McCormick
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: The Medical Records, Address: The Clinical Center, Bethesda 14, Maryland

I

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: two minutes
DUE TO (b) Probable Hypoglycemia — unknown
DUE TO (c) Lymphosarcoma — 4-5 months

200.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): metastases to mediastinum, liver, bone marrow.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from October 23, 19 61 to December 2, 19 61 that (I) (we) last saw the deceased alive on December 2, 19 61, and that death occured at 9:25 AM from the causes and on the date stated above.

22a. SIGNATURE: J. David Heywood M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12-2-61
22c. PHYSICIAN'S NAME (Type): J. David Heywood M.D.
22d. ADDRESS: The Clinical Center, National Institutes Of Health, Bethesda 14, Md.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit 12-3-61
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Papillion Cemetery
23d. LOCATION (City, town or county) (State): Papillion, Nebraska

24 FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Maryland
25a. REC'D BY REGISTRAR: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14244 **CERTIFICATE OF DEATH** 14214

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wash San & Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville 1152-2
d. STREET ADDRESS: 625 Sheridan St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle Edgar Last Towles
4. DATE OF DEATH: Month 12 Day 23 Year 1961
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-26-97
9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor
10b. KIND OF BUSINESS OR INDUSTRY: P.O. Dept
11. BIRTHPLACE (County & State, or foreign country): Wash D.C
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Joseph Towles
14. MOTHER'S MAIDEN NAME: Frances Upton
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give year or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 h

331 X

DUE TO (b) Cerebral atherosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Subacute bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1, 1961, to Dec 23, 1961, that (I) (~~we~~) last saw the deceased alive on Dec 21, 1961, and that death occured at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: M F Ottman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/23/61
22c. PHYSICIAN'S NAME (Type): M.F. OTTMAN
22d. ADDRESS: 401 Kennedy St NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried
23b. DATE THEREOF: Dec-27-61
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City, town or county): Rock Creek Rd. (State): D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Arthur L. Talley
ADDRESS: 254 Carroll St. N.W. D.C.
25a. RECD BY REGISTRAR DATE: DEC 27 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14245 **CERTIFICATE OF DEATH** 14215

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 4½ days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norbeck 14
d. STREET ADDRESS: 1 Norwood Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Curt — Middle: — Last: Von Seydlitz
4. DATE OF DEATH: Month: December — Day: 13 — Year: 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 15, 1872
9. AGE (In years last birthday): 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (County & State, or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA BILATERAL
(b): ARTERIOSCLEROTIC HEART DISEASE
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
491X

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12-10, 1961, to 12/13, 1961, that (I) (we) last saw the deceased alive on 12/13 1961, and that death occured at 11 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/13/61
22c. PHYSICIAN'S NAME (Type): LUCIANO I. LEAL, M.D.
22d. ADDRESS: GAITHERSBURG, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12/15/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 18 61
25b. REGISTRAR'S SIGNATURE: Arthur L. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

= HATEFUL, RESIDENTIAL HEART DISEASE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14216

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 63 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 2609 Kirkwood Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: Dorothy — Last: Walling
4. DATE OF DEATH: Month: December — Day: 18 — Year: 19 61
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 4, 1916
9. AGE (In years last birthday): 45 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William W. Giles
14. MOTHER'S MAIDEN NAME: Gertrude Fields
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 218-20-2343
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 8 Hours

332 X

DUE TO (b) Cerebral Embolus with brain damage — 5 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rheumatic Heart Disease - Mitral Stenosis with left atrial thrombus

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from October 16, 19 61 to December 18 19 61, that ☒ (we) last saw the deceased alive on December 18 19 61, and that death occured at 11:40 AM from the causes and on the date stated above.

22a. SIGNATURE: Paul A. Ebert M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 12/18/61
22c. PHYSICIAN'S NAME (Type): Paul A. Ebert, M.D.
22d. ADDRESS: The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/21/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Francis Gasch's Sons Hyattsville, Maryland
25a. REC'D BY REGISTRAR — DATE: DEC 21 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14247

CERTIFICATE OF DEATH

14217

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY COUNTY MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): TAKOMA PARK
c. LENGTH OF STAY IN 1b: 1 mo & 13 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): WASHINGTON SANITARIUM & HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver SPRING 29
d. STREET ADDRESS: 1234 DALE DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEONARD Middle: GRIFFITH Last: WALLIS

4. DATE OF DEATH: Month: 12 Day: 5 Year: 1961

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-24-80
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days: 11 IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOUTHERN RAILWAYS RY.
10b. KIND OF BUSINESS OR INDUSTRY: SO. RAILWAYS
11. BIRTHPLACE (State or country): Md. ~~MONTGOMERY COUNTY~~ BALTIMORE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM H. WALLIS
14. MOTHER'S MAIDEN NAME: MARIA GRIFFITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 718-10-5746
17. INFORMANT: HOSPITAL CHART- Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia - Arteriosclerotic Heart Disease
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April, 1960 to Dec. 5, 1961, that (I) (we) last saw the deceased alive on Dec. 4, 1961, and that death occured at 4:13 AM. from the causes and on the date stated above.

22a. SIGNATURE: J. Marion Bankhead M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/5/61
22c. PHYSICIAN'S NAME (Type): J. Marion Bankhead
22d. ADDRESS: 9241 Col. Blvd. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 12/7/61
23c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
23d. LOCATION (City, town or county) (State): WASHINGTON D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond A. Ziska
ADDRESS: Wagner-Pumphrey Funeral Home 8434-Georgia Ave. S.S., Md.
25a. REC'D BY REGISTRAR DATE: DEC 7 '61
25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14248 14218

1. PLACE OF DEATH
e. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Montgomery General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gaithersburg
d. STREET ADDRESS: none
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐: unknown

3. NAME OF DECEASED (Type or print): First: Nona — Middle: Burns — Last: Warthen

4. DATE OF DEATH: Month: December — Day: 24 — Year: 19 61

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 8/19/1883
9. AGE (In years last birthday): 78 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Clifford Burns
14. MOTHER'S MAIDEN NAME: Roseanna Glaze

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): unknown (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217 28 6033
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Compression fracture T-9+12 — 10 days
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
902.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerosis, Generalized

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Patient fell out of bed, at home

20c. TIME OF INJURY: Hour 8 a.m. p.m. — Month, Day, Year: 12-14 1961
20d. INJURY OCCURRED: While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Gaithersburg (County): Mont. (State): Md.

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Dec. 15, 1961, to Dec. 24, 1961, that (I) (~~we~~) last saw the deceased alive on 12-24 1961, and that death occured at 3:30 p.m., from the causes and on the date stated above.

22a. SIGNATURE: Jack Schumacker M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-26-61
22c. PHYSICIAN'S NAME (Type): Jack Schumacker
22d. ADDRESS: Gaithersburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Dec. 28 1961
23c. NAME OF CEMETERY OR CREMATORY: Damascus
23d. LOCATION (City, town or county): Damascus (State): Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Francis H. Barber — ADDRESS: Laytonsville, Md.
25a. REC'D BY REGISTRAR — DATE: DEC 29 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14249 **CERTIFICATE OF DEATH** 14219

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Washington San't Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8658 Piney Branch Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: Allie; Last: Weaver

4. DATE OF DEATH: Month: Dec; Day: 12; Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐
8. DATE OF BIRTH: 8-16-1891
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Civil Service
10b. KIND OF BUSINESS OR INDUSTRY: U.S. gov't
11. BIRTHPLACE (County & State, or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ~~XXXXXXXXXXXX~~ NEWTON Robert H. Daniel
14. MOTHER'S MAIDEN NAME: Mary S. Benson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ****
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis Acute — INTERVAL BETWEEN ONSET AND DEATH: 6 days
420.1
DUE TO (b): Hypertensive Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Hypertension

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9-23- 1961, to 12-12 1961, that (I) (we) last saw the deceased alive on 12-11- 1961, and that death occured at 7:20 A.M. from the causes and on the date stated above.

22a. SIGNATURE: S A Hillman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/12/61
22c. PHYSICIAN'S NAME (Type): SAMUEL A. HILLMAN
22d. ADDRESS: 8829 FLOWER AVE. S.S. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/15/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Prince Georges Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Raymond H. Ziska — ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7/61

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14250

CERTIFICATE OF DEATH

14220

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1503 Ladd Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 8207 New Hampshire Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

1656-2

3. NAME OF DECEASED (Type or print): First: Alice Middle: Cecelia Last: Welch
4. DATE OF DEATH: Month: Dec Day: 11 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 23, 1898
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William F. O'Beirne
14. MOTHER'S MAIDEN NAME: Teresa McDonald
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service): ----------
16. SOCIAL SECURITY NO.: 220-32-6153
17. INFORMANT: Alice Welch Mathewson Address: 1503 Ladd St. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from ....., 19....., to Dec. 11, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 11, 1961, and that death occured at 8 P.M, from the causes and on the date stated above.

22a. SIGNATURE: Raymond Bradshaw, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Dec 11, 1961
22c. PHYSICIAN'S NAME (Type): Raymond Bradshaw
22d. ADDRESS: 345 University Blvd W. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/15/61
23c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
23d. LOCATION (City, town or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Raymond W. Riska ADDRESS: 8434 Georgia Avenue
Warner E. Pumphrey, Inc. Silver Spring, Maryland
25a. REC'D BY REGISTRAR DATE: DEC 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after [illegible]. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14251

14221
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Poolesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RFD#2 Dickerson, MD.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Dickerson
d. STREET ADDRESS: RFD#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: CLINTON Middle: Last: WELLS.

4. DATE OF DEATH: Month: DECEMBER Day: 5 Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 30, 1892

9. AGE (In years lost birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economist

10b. KIND OF BUSINESS OR INDUSTRY: AGRIC. Dept

11. BIRTHPLACE (State or foreign country): WASHINGTON

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES WELLS

14. MOTHER'S MAIDEN NAME: EDITH SQUIRES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): 18 DAYS

16. SOCIAL SECURITY NO.:

INFORMANT: Elizabeth Wells — Address: RD#2 Dickerson, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.
331X
DUE TO (b) cerebral arteriosclerosis — 2 years
DUE TO (c) Arteriosclerosis — 2 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Dec, 1961, to 5 Dec, 1961, that I last saw the deceased alive on 5 Dec, 1961, and that death occurred at 1 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: John S. Fawcett M.D. — ADDRESS (Street, city or town, state): Damascus — DATE SIGNED: 12/5/61

PHYSICIAN'S NAME (Type): P.O. BOYD, MARYLAND

22a. ~~BURIAL~~, CREMATION, ~~REMOVAL (Specify)~~: 12/5/61

22b. DATE THEREOF

22c. ~~NAME OF CEMETERY~~ OR CREMATORY: Lee's

22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home — ADDRESS: 300-4th N.E.

24a. REC'D BY REGISTRAR — DATE: DEC 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

VS A1S (4)
1SM 9/5B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14252 **CERTIFICATE OF DEATH** 14222

Item 8 Film G302 12/8/61 lgk

Item 2 Film G305 1/18/62 mb

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Bethesda
d. STREET ADDRESS: 2201 Old Georgetown Town LeDroit Gardens Nsy/Hyd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Harriet; Middle: ; Last: Wentworth
4. DATE OF DEATH: Month: December; Day: 3; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/16/1874
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fairchild
14. MOTHER'S MAIDEN NAME: NOT AVAILABLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give were or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (daughter-in-law) Address: Jeanne Wentworth, 1312 Clifton St., N.W. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH: unknown
153.1
DUE TO (b): Carcinoma of transverse colon — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/25, 1961 to 12/3, 1961 that (I) (we) last saw the deceased alive on 12/3, 1961, and that death occured at 5 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm Y. Marcus M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/3/61
22c. PHYSICIAN'S NAME (Type): WM Y. MARCUS
22d. ADDRESS: 10620 Georgia Ave. Silver Spring, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12/5/61
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
23d. LOCATION (City, town or county) (State): Bladensburg, Maryland.

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters
ADDRESS: 254 Carroll St. N.W.
25a. REC'D BY REGISTRAR DATE: DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14253

CERTIFICATE OF DEATH

14223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove remaining papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 7/61

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 83 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Springs
d. STREET ADDRESS: 1905 East-West Highway Apt202
e. IS RESIDENCE ON A FARM? YES [ ] NO [X]

3. NAME OF DECEASED (Type or print): First: Luke — Middle: Matthew — Last: WHITE

4. DATE OF DEATH: Month: December — Day: 31 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasion

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 23 April 1937n

9. AGE (In years last birthday): 24 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. Navy

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Irvine WHITE

14. MOTHER'S MAIDEN NAME: Mary FORBES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: (Wife) Jeanne A. WHITE — Address: Silver Spring, Md. 1905 E. W. Hwy.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 14 mos.
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

199X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [XX] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that XX (this hospital) attended the deceased from Sept. 9, 1961 to Dec. 31, 1961, that XX (we) last saw the deceased alive on Dec. 31, 1961, and that death occured at 1:15A M, from the causes and on the date stated above.

22a. SIGNATURE: William P. Urshel M.D.

ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22b. DATE SIGNED: December 31, 1961

22c. PHYSICIAN'S NAME: William P. URSHEL LT, MC, USN

22d. ADDRESS: U. S. Naval Hospital Bethesda, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Shipment

23b. DATE THEREOF: 1-2-62

23c. NAME OF CEMETERY OR CREMATORY: Rosedale Crematory

23d. LOCATION (City, town or county) (State): Orange, N.J.

24. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: 7557 Wisconsin Ave. R. A. Pumphrey Funeral Home Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE: JAN 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

M

1

[redacted] STATE HEALTH DEPT.

M

99

I

2

2

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, [redacted] execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14254

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14221

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural, Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 45 Bethesda
d. STREET ADDRESS: 1 9207 Adelaide Court
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Delbert; Middle: Swan; Last: Wicks

4. DATE OF DEATH: Month: December; Day: 17; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: July 17, 1911

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S. NAVY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Providence, R. I.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Delbert Samuel Wicks

14. MOTHER'S MAIDEN NAME: Anna Arnold

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Wife): Elsie R. Wicks
Address: 9207 Adelaide Ct., Bethesda, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction
420.1
DUE TO (b): Coronary Occlusion
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE Frank J. Broschart M.D.

EXAMINER'S NAME (Type) Frank J. Broschart

Address (Street, city, town, or county):

DATE SIGNED 18 December 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 12-18-61

22c. NAME OF CEMETERY OR CREMATORY: Highland Memorial Park

22d. LOCATION (City, town, or country) (State): Providence, R.I.

23. FUNERAL DIRECTOR James Evans
ADDRESS: W.W.Chambers Funeral Home, Washington, D. C.

24a. REC'D BY REGISTRAR DATE DEC 21 '61

24b. REGISTRAR'S SIGNATURE [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14255

CERTIFICATE OF DEATH

Item 16 Film G305 1/25/62 iwk

14225

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 5833 Osceola Court

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 57 Bethesda
d. STREET ADDRESS: 5833 Osceola Court
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ione — Middle: Elizabeth — Last: Wieker

4. DATE OF DEATH: Month: Dec. — Day: 20 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 7/25/1912

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months: 4 — Days: 25
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ---------

11. BIRTHPLACE (County & State, or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas C. Anderson

14. MOTHER'S MAIDEN NAME: Lura M. Matteson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give were or dates of service):

16. SOCIAL SECURITY NO.: 556-07-9669 None

17. INFORMANT: John L. Wieker-Husband-same 2d
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Gastrointestinal Hemorrhage	1 hour
DUE TO (b)	Portal Hypertension	1 year
DUE TO (c)	Metastatic Carcinoma Liver (Primary Rectum)	1 1/2 years

154 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from May, 1960, to Dec. 20, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 19, 1961, and that death occured at 5 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Clifton R. Gruver M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/20/61
22c. PHYSICIAN'S NAME (Type): Clifton R. Gruver
22d. ADDRESS: 915 19th St. N.W. Wash 6 DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/22/61
23c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
23d. LOCATION (City, town or county) (State): Rockville, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland

25a. REC'D BY REGISTRAR DATE DEC 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14256

CERTIFICATE OF DEATH

14236

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5320 Yorktown Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 Bethesda
d. STREET ADDRESS: 5320 Yorktown Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ORIS Middle: BENTON Last: WILLIAMS
4. DATE OF DEATH: Month: Dec Day: 3 Year: 1961
5. SEX: MALE
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6/27/12
9. AGE (In years last birthday): 49 yrs. IF UNDER 1 YEAR: Months 5 Days 6 IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James McKee Williams
14. MOTHER'S MAIDEN NAME: Emma Grimson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 023-03-4840
17. INFORMANT: Joyce M. Williams, Wife-same 2d Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE — INTERVAL BETWEEN ONSET AND DEATH: YEARS
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that (I) (~~this hospital~~) attended the deceased from _____ 1948 to Dec 3 1961, that (I) (~~we~~) last saw the deceased alive on Nov 7 1961, and that death occurred at 6:53 P.M. from the causes and on the date stated above.

22a. SIGNATURE: DeWitt E. DeLawter M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12-3-61
22c. PHYSICIAN'S NAME (Type): DeWITT E. DeLAWTER
22d. ADDRESS: 8025 ABERDEEN Rd. Bethesda 14, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/6/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery
23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey, Bethesda, Maryland
25a. REC'D BY REGISTRAR DATE DEC 6 '61
25b. REGISTRAR'S SIGNATURE: Carlton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14257 **CERTIFICATE OF DEATH** 14227

1. PLACE OF DEATH
a. COUNTY: Montgomery MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Cedar Croft N Home.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 5811 - 6th. St N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mae Middle: F Last: Wilson
4. DATE OF DEATH: Month: December Day: 10 Year: 19 61.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 14, 1879
9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George A Frey
14. MOTHER'S MAIDEN NAME: Mary Rudy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs H.E. Matthias- 5811 -6th St. D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 d
490X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Cardio vasc. disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 1955, to Dec. 10, 1961, that (I) (we) last saw the deceased alive on Dec. 8 1961, and that death occured at 3 A.M, from the causes and on the date stated above.

22a. SIGNATURE: M F Ottman M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): M. F. OTTMAN
22d. ADDRESS: 401 Kennedy St NW

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 12- 12-61
23c. NAME OF CEMETERY OR CREMATORY: Leek s Crematoium
23d. LOCATION (City, town or county) (State): Washington D.C,

24 FUNERAL DIRECTOR'S SIGNATURE: Lee F,,neral Home - Washington D.C.
ADDRESS
25a. REC'D BY REGISTRAR DATE DEC 13 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

14258 **CERTIFICATE OF DEATH** 14228

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 1 hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Md
d. STREET ADDRESS: 95 E. Wayne Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella Middle: Lost: Windish
4. DATE OF DEATH: Month: 12 Day: 30 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct. 22. 1878
9. AGE (In years lost birthday): 83 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seamstress
10b. KIND OF BUSINESS OR INDUSTRY: Sheraton Park Hotel
11. BIRTHPLACE (State or foreign country): Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Jones
14. MOTHER'S MAIDEN NAME: Hannah Everett

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 577-10-2508A
17. INFORMANT: Mrs. James F. Loyd Address: (same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis — 1 day
DUE TO (b): Ventricular Fibrillation — 1 minute
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Thrombophlebitis leg - Pulmonary embolism with infarction
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov 29, 1961 to Dec 30, 1961, that (I) (we) last saw the deceased alive on 12/30/1961, and that death occurred at 11:50 a.m. from the causes and on the date stated above.

22a. SIGNATURE: Robert R Hottel M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/30/61
22c. PHYSICIAN'S NAME (Type): Robert R Hottel
22d. ADDRESS: 1222 Monroe St NW DC

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Jan. 2. 1962
23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Prince Geo. Co. Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: J. Arthur Walters ADDRESS: 254 Carroll St NW. DC
25a. REC'D BY REGISTRAR DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14259 **CERTIFICATE OF DEATH** 14229

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 day
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Suburban Hosp

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring Md.
d. STREET ADDRESS: Bot 271 - Brook Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Mearel Middle: W. Last: Wise
4. DATE OF DEATH: Month: Dec Day: 5 Year: 1961

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 8-14-25
9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian
10b. KIND OF BUSINESS OR INDUSTRY: N.I.H.
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Wise
14. MOTHER'S MAIDEN NAME: Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): W.W. II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Wife Hattie Wise Address: Silver Spring RT. 2 Good Hope Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO (b) Obstructive Jaundice — 6 weeks

DUE TO (c) Recurrent carcinoma of stomach — 2 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

2Da. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
2Dd. INJURY OCCURRED While at work [ ] Not While at work [ ]
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Dec 1, 1961 to Dec 5, 1961, that (I) (we) last saw the deceased alive on Dec 5 1961 and that death occured at 9:45 P.M. from the causes and on the date stated above.

22e. SIGNATURE: John J Curry M.D.
ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22b. DATE SIGNED: 12/5/61
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: 10620 Georgia Ave Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/9/61
23c. NAME OF CEMETERY OR CREMATORY: Sandy Spring,,
23d. LOCATION (City, town or county) (State): Sandy Spring, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
25e. REC'D BY REGISTRAR DATE DEC 11 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14260 14230

Items 3 & 10b, Film 0306 2/5/62 iwk

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San + Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Dist. of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 5732 2nd St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

75

M

I

3. NAME OF DECEASED (Type or print): First: Anna; Middle: Laurie (LAURI); Last: Wyke (Gilchrist)
4. DATE OF DEATH: Month: Dec; Day: 26; Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-30-97
9. AGE (In years last birthday): 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: N.S.A. (National Security Agcy)
11. BIRTHPLACE (County & State, or foreign country): West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: Daniel N. Gilchrist
14. MOTHER'S MAIDEN NAME: Betsy Ann Wigal
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no — (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 246-12-3174
17. INFORMANT: Mrs Betty Everley 4804 — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Manifest weakness, Cachexia — INTERVAL BETWEEN ONSET AND DEATH: 1 month

157 X

DUE TO (b): Carcinoma of the Pancreas — Primary

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/22/61, 19.61 to 12/26/61, 19.61, that (I) (we) last saw the deceased alive on 12/26 1961, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Charles Wolohan MD M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Charles Wolohan
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 12/28/1961
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln
23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Francis Gaschs Sons — ADDRESS: Hyattsville, Md
25a. REC'D BY REGISTRAR: DATE JAN 2 '62
25b. REGISTRAR'S SIGNATURE: Mathew S. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (4)
15M 7/61

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14261 **CERTIFICATE OF DEATH** 14231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Wheaton
c. LENGTH OF STAY IN 1b: 19 da
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Wheaton Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x-3
d. STREET ADDRESS: 742 Van Buren St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Naomi; Middle: R.; Last: YOPPS
4. DATE OF DEATH: Month: Dec.; Day: 31; Year: 1961
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 7, 1881
9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: James Garner
14. MOTHER'S MAIDEN NAME: Louisa Weaver
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Otto E. Yopps 742 VanBuren St.N.W.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days.
DUE TO (b) Cardio-Vascular-Renal Disease — Sev. yrs
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility - Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from Nov., 1961 to Dec. 31, 1961, that (I) (~~we~~) last saw the deceased alive on Dec. 30, 1961, and that death occured at 4:40 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Lynwood Heiges, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 12/31/61
22c. PHYSICIAN'S NAME (Type): LYNWOOD HEIGES, MD, FACA
22d. ADDRESS: 6940 Piney Branch Road N.W. Washington 12, D.C.

23a. BURIAL, ~~CREMATION, REMOVAL (Specify)~~: burial
23b. DATE THEREOF: 1/2/62
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Pr.Geo.Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: The P.A. Hines Co.
ADDRESS: 2901 14th St. N.W.
25a. REC'D BY REGISTRAR DATE JAN 3 '62
25b. REGISTRAR'S SIGNATURE: Arthur S. Thomas